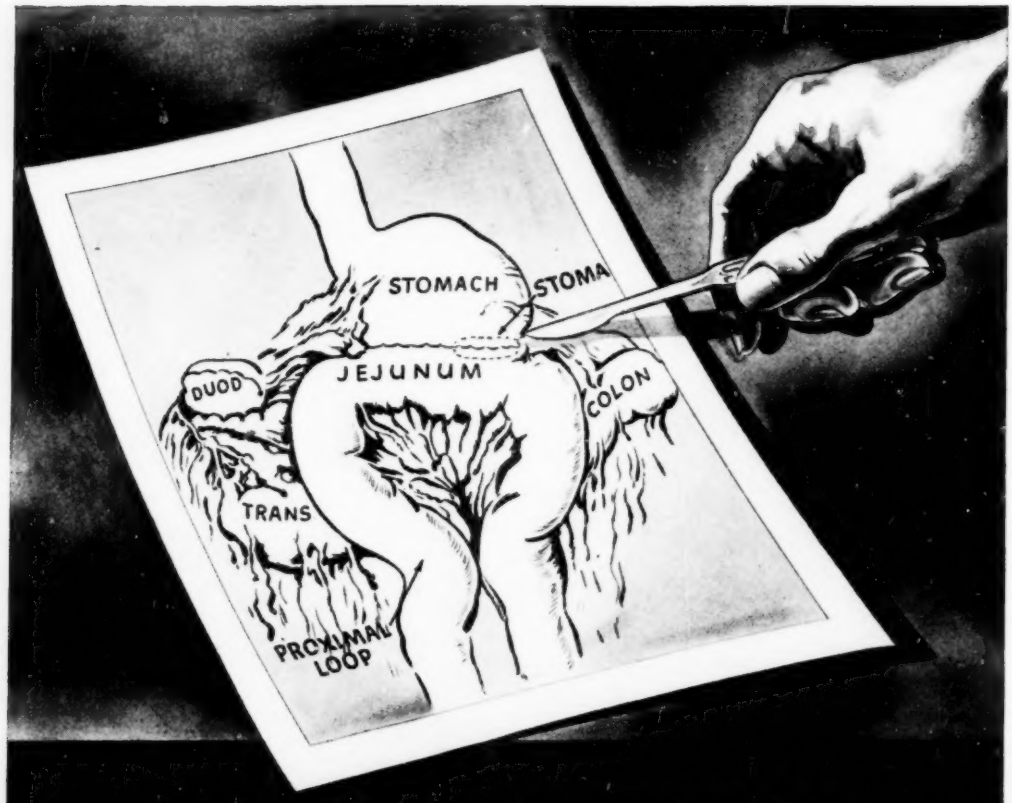
ARIZONA MEDICINE

Journal of

ARIZONA STATE MEDICAL ASSOCIATION

CONTENTS

Volume 1 *January-February, 1944* *Number 1*



New, effective treatment for the most baffling Peptic Ulcer

Gastrojejunal ulcer is described as the type most difficult to treat satisfactorily. 1.

A new preparation, Phosphaljel, is effective in treating these highly resistant lesions. 2.

Phosphaljel is antacid, astringent, demulcent, pleasantly flavored. It is indicated in those cases associated with pancreatic juice deficiency, diarrhea, or low phosphorus diet.

Available in 12-fluidounce bottles. A pharmaceutical of John Wyeth & Brother, Division WYETH Incorporated, Philadelphia.

1. MARSHALL, S. F., and DEVINE, J. W., Jr.: Gastrojejunal Ulcer, S. Clin. North America, 743-761 (June) 1941.

2. FAULEY, G. B.; FREEMAN, S.; IVY, A. C.; ATKINSON, A. J., and WIGODSKY, H. S.: Aluminum Phosphate in the Therapy of Peptic Ulcer, Arch. Int. Med. 67: 563-578 (March) 1941.

PHOSPHALJEL* *Wyeth's** ALUMINUM PHOSPHATE GEL

*REG. U. S. PAT. OFF.

PRESIDENT'S PAGE

IN this first issue of "*Arizona Medicine*" your president feels that it is incumbent upon him to again call to the attention of every member of our association the insidious attempt which is being made to supplant the private practice of medicine by complete federalization. Specifically the Wagner-Murray-Dingell bill now before Congress, an analysis of which is published elsewhere in this Journal, if passed, will make the Surgeon General of the United States Public Health Service the dictator of medical practice and of dentistry, nursing and hospitalization as well.

The above named bill is a broad, far reaching socialistic measure and tucked away in what was a rather inconspicuous corner, until recent publicity brought it to light, is the section pertaining to our profession. It is worth while to reiterate details. This Czar, a political appointee, would have authority to employ doctors at fixed salaries and fees, to provide medical care, to determine arbitrarily which hospitals or clinics could provide services, to fix hospital room and ward rates. The present one percent Social Security tax paid by self-employed individuals, such as physicians, would be raised to seven percent, while the one percent now paid by employees and corporations would be raised to six percent for each of these groups. Think of the effect of a ten percent tax increase on labor and on capital! Contemplate for a moment the tremendous bureaucracy and the enormously increased federal payroll resulting! Of the twelve billion dollars raised annually, three billion would be set aside for use in administrating the medical provisions of the law. Enough funds would be at hand for the government to take over and operate all of the medical schools of the country should those in charge not approve of the private administration of these institutions.

Here before us we have the beginning of complete regimentation. Do not think that medicine alone is involved. Medicine was chosen first because it is most vulnerable, but law, engineering, banking and all other walks of life would most surely follow. The American Bar Association has already, in no uncertain terms, condemned this attempted usurpation.

We are told that medicine constitutes such a small group that it can be politically disregarded. Let us by every means possible refute such error. Let each one of us start his own campaign of education now to give to our legislators, to our patients and to our friends in other callings, the real facts of this impending legislation. Let us work doubly hard to take up the burden of the fifty thousand politically impotent physicians who are in the armed forces, to prevent the consummation of this colossal mistake. If we are fighting for four freedoms let us fight for one more, for the simple, democratic, American freedom to practice medicine.

O. E. Utzinger, M.D.

THE REPAIR OF SEVERED TENDONS A NEW TENDON SUTURE

CLARENCE E. REES, M. D.
Rees-Stealy Clinic
San Diego, Calif.

THE surgical repair of injuries in which tendons are severed merits special consideration because of (1) the relative avascularity of tendons, (2) the histological structure of tendon tissue, and (3) the tonicity of the muscles, which is accentuated by injury. The first requires meticulous asepsis; the second requires a special type of suture; the third requires splinting and protection of the line of suture from unusual tension.

At the outset I would like to stress the importance of aseptic preparation and technique, and to suggest that repair be attempted only under the best conditions available. Tendon repair should not be considered as a surgical procedure suited to ordinary office practice; it merits the best facilities and instruments obtainable.

Whether primary tendon repair or preliminary treatment of the wound with secondary or delayed suture of the tendon is to be carried out, requires careful consideration and a keen appreciation of the factors involved. Each operator must call on his own experience and ingenuity to determine the proper procedure in the individual case. The character of the wound and its cause, the time that has elapsed since the injury, and the type of first-aid treatmen administered before the patient is seen by the surgeon, are among the deciding factors. Wounds made by relatively clean and sharp objects, and seen within the arbitrary six-hour period following injury, may be repaired at once providing there is no evidence of active infection. If more than six hours has elapsed since injury; if the wound was made by dirty objects or contains foreign material and is obviously contaminated; or if there is marked laceration of tissue, suturing of the tendons should not be attempted at the time of the initial surgical treatment. In such cases the likelihood of tendon slough with loss of tissue would complicate the then necessary later repair. At the time of preliminary treatment, however, the proximal end of the tendon may be sutured to some surrounding firm structure in order to minimize retraction and thus facilitate the second procedure. Bove has reported a method of tendon transfixion by means of a small steel pin which passes through the tendon and surrounding structures at some distance proximal to the wound. This is described as a tendon suture method but it could be used to advantage in transfixing tendons which cannot be sutured until later. Secondary repair should not be attempted until all signs of inflammation have subsided,—the color of the tissues should be normal and all induration should have disappeared.

The availability of the sulfonamides for local instillation should not influence the operator to discard the lessons of experience and cause him to undertake too extensive operative repair, nor should it cause him to lessen his observance of aseptic technique. The value of these drugs should not be underestimated but our reliance upon them should not encourage us to overreach or to become careless.

The treatment of contaminated and lacerated wounds varies from wound freshening plus the use of a sulfonamide to the radical debridement procedures of the last war. The condition of the wound at the time it is first observed must determine the course to follow. Three requirements, however, would seem to be apparent, namely, that all visible foreign material should be removed; that all devitalized tissue should be removed; and that only the minimum amount of suture material consistent with good repair should be allowed to remain in the wound.

The two-stage procedure has received sufficient support to prove its worth and one should not be influenced against it by fear of criticism from colleagues or the possibility of malpractice. Experience has shown that in certain wounds and under certain circumstance, primary suturing is not the proper procedure. An explanation of the situation to the patient and/or relatives and employer avoids the dan-

Read before the Arizona State Medical Society, Tucson, Arizona, May the 1st, 1943.

ger of malpractice suits and changes the psychological viewpoint of the patient from one of discouragement regarding his disability to one of hopeful expectancy and eagerness for his secondary repair.

It is not necessary to stress the importance of careful examination of tendon function distal to the site of injury, prior to repair. Such examination is basic in the treatment of injuries.

The preoperative preparation and general operating technique have been well outlined by Mason and others. The preoperative preparation consists of shaving, and cleansing the wound and surrounding parts with soap and large quantities of water. Common antiseptics should not be used because of their distructive action on exposed tissues. A sphygmometer cuff placed well above the operative field provides hemostasis, and the entire dissection, to the point at which the tendons are recovered and are ready for suturing, is carried out before the pressure in the cuff is released. With the release in pressure all bleeding points are ligated with the smallest ligature material consistent with the size of the vessels. When hemosasis is complete the tendon is sutured. The wound is then closed and pressure dressing is applied.

If necessary, the line of incision should be extended without hesitation. Generally speaking, the midline of the fingers should be avoided and the palmar creases should not be crossed. When the proximal end of the tendon has retracted a second incision should be made high over its normal course in order to recover the end of the tendon, replace it in its channel, and draw it into the operative field. This would seem to be a much better procedure than the endless blind fishing for a lost end. The use of the Esmark bandage to deliver a proximal tendon into the site of operation has not been of help in our experience.

In lacerated wounds with loss of covering, every attempt should be made to cover the tendon either with fat or skin as the tendon tends to slough on exposure. Contact between lines of suture and between suture lines and drains should be avoided since healing is retarded in both instances.

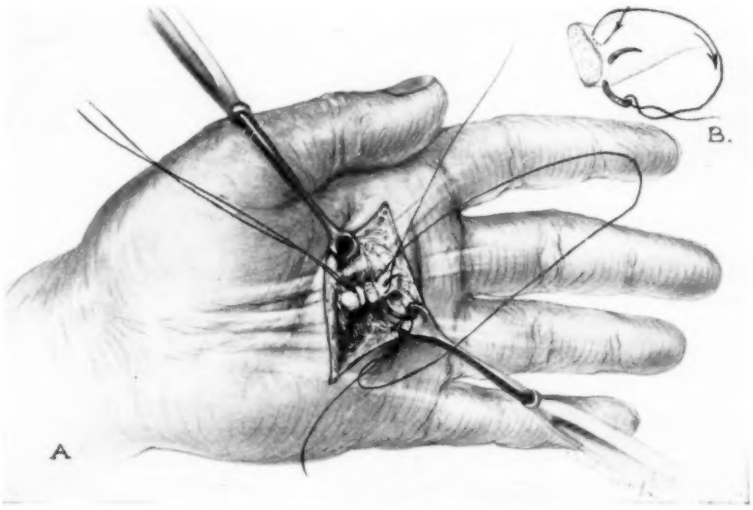


FIGURE I.
One encircling suture placed and the second one being placed. Insert shows direction of needle in making inside loop.

The actual repair of recently severed tendons is not the simple procedure that is usually demonstrated in text-books and articles on the subject. The illustrations are usually diagramatic and do not approximate the situation encountered or the finished operation. Actually tendons are made up of white collagenous fibers so loosely bound together that the interstitial tissue is not firm enough to hold a suture under muscle tension. It is quite apparent that repair by simply suturing the ends together is not possible and that innovations are necessary

to obtain satisfactory results. In any satisfactory method, the suture must encircle more or less of the fibers in a noose-like manner in order to have stability. All accepted procedures for suturing tendons follow this principles.

It has been demonstrated that when suture material lies between the sutured ends, healing is retarded because foreign body reaction may supercede fibrosis. Furthermore, it has been demonstrated that contricting delay healing because of the retardation of blood circulation which at best is minimal in these structures. The most advocated methods merely stabilize the ends in close proximity and depend upon splinting to avoid tension until healing has progressed sufficiently to allow motion.

When tendons are sutured in the usual manner there is often a widening at the line of union because the ends tend to fray. Then when the ends are approximated they spread and an actual increase in bulk in addition to that of the approximating sutures is produced at the line of union. The disadvantage of prolonged splinting is that the tendon ends heal to the surrounding sheath or structures as well as to each other and unless careful follow-up therapy and observation are available the result may be fixation at the site of suture or separation of the ends with resulting diminution or loss of function.

We believe that the following method of suturing tendons meets all the requirements for good tendon repair and avoids some of the disadvantages of the advocated methods: (1) it does not interfere sufficiently with the circulation of the central fibers to prevent prompt healing; (2) it is stable enough to permit early motion of the injured tendon; (3) it maintains the normal tendon contour at the site of union.

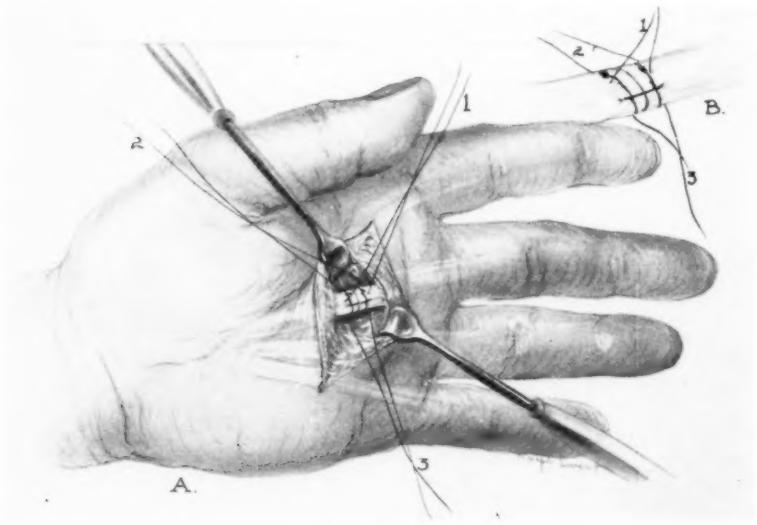


FIGURE II.
Placement of the tension suture proximal to the encircling sutures.

Two different sutures are used, an encircling suture and the tension sutures.

In our method, the encircling suture passes around the tendon a short distance from its lacerated end in a series of inside loops. The depth of these loops is in proportion to the size of the tendon but should not be deeper than one-eighth the diameter which will permit the approximation of well over 56 per cent of the cut surfaces of the tendon not subjected to constriction. The suture should be at a right angle to the long axis of the tendon so that it will not tend to loosen under strain. It should be moderately taut as it encircles but should not constrict the tendon to the point of forming a marked indentation.

The encircling sutures should be placed with the loops on the inside. This is done by passing the needle into the tendon in the direction which is opposite to the progress of the suture. If the needle is inserted into the tendon in the same direction in which the suture is prog-

ressing the loops will be on the outside and the normal contour of the tendon will not be maintained under the tension of the approximating sutures.

This suture serves two purposes: it binds the fibers at the cut ends together so as to form reasonably firm structures for approximation, and it acts as a stabilizer for the tension sutures.

The suture material is as fine as the estimated tension involved will permit. For example, for extensor tendons of the finger or for flexor tendons within the digital sheaths, arterial silk is ample if its tensile strength is correct. Larger tendons at the wrist may require No. C silk. The tensile strength should be tested just prior to use.

The tension sutures pass through the diameter of the tendon just proximal to the encircling sutures. They are two or three in number depending upon the size of the tendon and are placed equidistant from each other. When these are tied with proper tension the cut ends of the tendon are accurately approximated.

All sutures should be tied three times firmly.

When the encircling and approximating sutures are properly placed the former stabilize the latter by grasping the fibers at the periphery of the tendon, with the loops on either side of the point where the sutures intersect. This grasping or constricting action is transmitted to a lesser degree to the loops on each side.

A splint or cast is applied for three or four days, or during the period in which bacterial incubation would be accelerated by motion. Then, if the wound is clean the splints are removed, except at night, and motion started. Motion should be increased daily, first passively, then actively, to a point just under the pain level. Splints are applied at night for three weeks to avoid involuntary strain on the suture lines. Moderate normal activity is permitted after three weeks but excessive strain should be avoided for several months following repair.

SUMMARY

The factors to be considered in the repair of severed tendons are briefly discussed and a method for suturing such tendons which meets all the requirements for a satisfactory result and avoids some of the disadvantages inherent in the commonly accepted procedures, is described.

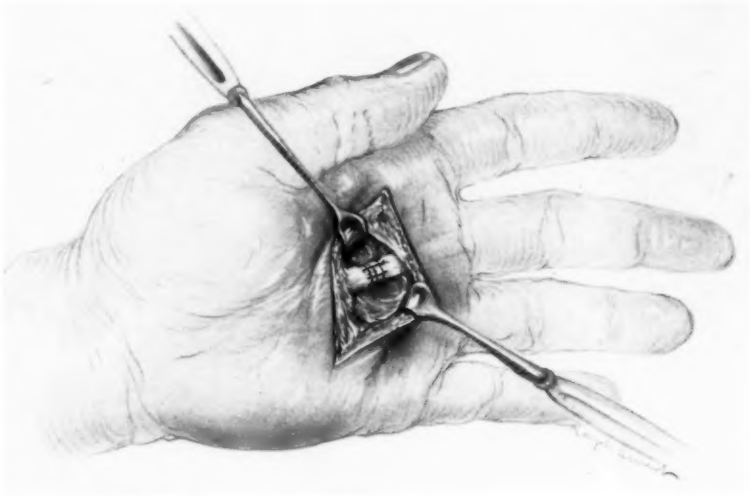


FIGURE III.
Completed operation. Note absence of widening of the tendon at the line of suture.

These sutures are of heavier material than that of the encircling sutures, but the finest material consistent with the strain to be put upon it should be used. Here again the size is proportionate to the size of the tendon and the strength of the muscle and varies from No. C to No. 2 silk. Again it is important to test the suture for tensile strength before using it.

REFERENCE

Bove, C. Suturing of Flexor Tendons of Hand (Transfixion). M. Rec. 153: 94 (Feb. 5) '41.

DIGEST OF THE WAGNER BILL

THE Wagner Bill, S1161, has been introduced in the U. S. Senate and has been referred to the Senate Committee on Finance. Following is an analysis of the measure prepared by The Bureau of Legal Medicine and Legislation of the A.M.A. It was published in the June 26, 1943 issue of the Journal of A.M.A., the August issue of the Ohio State Medical Journal, and various other medical publications throughout the country. It should be read by every doctor, and every nurse, and the owner of every private hospital throughout the United States. Hearings on the bill before the above Committee may be started at anytime.

Referred to generally as embodying an Americanized Beveridge plan but offered in Congress, according to Senator Wagner, "simply as a basis for legislative study and consideration," legislation was introduced, June 3, in the Senate by Senator Wagner, New York, for himself and Senator Murray, Montana, and in the House by Representative Dingell, Michigan, proposing to create a Unified National Social Insurance System (S. 1161; H. R. 2861). The Senate bill is pending in the Senate Committee on Finance and the House bill in the House Committee of Ways and Means.

The system proposed to be created will be financed in general from a trust fund established by a 6 per cent employee and a 6 per cent employer contribution on all wages and salaries, up to the first $3,000 a year, paid or received after December 31, 1943. Included in this proposed system will be a system of public employment offices, increased old age and survivors' insurance benefits, temporary and permanent disability insurance benefits, protection to individuals in the military service, increased unemployment insurance benefits under a federalized unemployment system, maternity benefits, medical and hospitalization insurance benefits, a broadening of the basis of the existing social security program to embrace some 15,000,000 persons now excluded, such a farm workers and domestic servants, employees of nonprofit institutions, independent farmers, members of the professions and other self-employed individuals, and a unified public assistance program. There follows an analysis of those provisions of the ninety page bill that appear to be of particular concern to medicine.

DISABILITY BENEFITS PLUS MEDICAL CARE

The bill broadens the existing social security coverage by providing for the payment of cash permanent disability benefits to beneficiaries. In addition to such cash benefits, the Social Security Board, through the Surgeon General of the Public Health Service, will be authorized to make provision for furnishing medical, surgical, institutional, rehabilitation or other services to disabled individuals, entitled to receive insurance benefits, if such services will aid in enabling such individuals to return to gainful work. Such services, it is contemplated, will be furnished "by qualified practitioners and through governmental and nongovernmental hospitals and other institutions qualified to furnish such services." In administering the provisions of this particular section of the bill, the Surgeon General and the Social Security Board will follow as far as applicable the procedure outlined by another section of the bill relating to medical, hospitalization and related benefits generally.

MEDICAL HOSPITALIZATION AND RELATED BENEFITS IN GENERAL

Section 11 of the bill proposes to add a new title to the Social Security Act, title IX, providing for a federal system of compulsory medical and hospitalization insurance for all persons covered under the old age and survivors' insurance, and their dependents. Each insured worker and his dependent wife and children will be entitled to receive general medical, special medical, laboratory and hospitalization benefits. In addition, the system is made elastic so that it may be enlarged in its coverage to admit other beneficiaries on a voluntary basis, such as self-employed individuals and employees of state and political subdivisions.

In order to appreciate the broad scope of this new title, consideration must initially be given to the meaning of the words and phrases used in it. The term "general medical benefit" means services furnished by a legally qualified physician, including all necessary services such as can be furnished by a physician engaged in the general practice of medicine, at the office, home, hospital or elsewhere, including preventive, diagnostic and therapeutic treatment and care, and periodic physical examinations.

The term "special medical benefit" means necessary services requiring special skill or experience, furnished at the office, home, hospital or elsewhere by a legally qualified physician who is a specialist with respect to the class of service furnished.

The term "laboratory benefit" means such necessary laboratory or related services, supplies or commodities, not provided to a hospitalized patient and not included as a part of the general or special medical benefit, as the Surgeon General of the United States Public Health Service may determine, including chemical, bacteriologic pathologic diagnostic and

therapeutic X-ray and related laboratory services, physical therapy, special appliances prescribed by a physician, and eye glasses prescribed by a physician "or other legally qualified practitioner."

The term "hospitalization benefit" means (1) not less than $3 and not more than $6 for each day of hospitalization, not in excess of thirty days, which an individual has had in a period of hospitalization; (2) not less than $1.50 and not more than $4 for each day of hospitalization in excess of thirty in a period of hospitalization; and (3) not less than $1.50 and not more than $3 for each day of care in an institution for the care of persons suffering from chronic ailments. The exact amount of the benefit between the minimums and maximums stated, will be fixed by the Surgeon General of the Public Health Service after consultation with the National Advisory Medical and Hospital Council to be created by the bill and after approval by the Social Security Board. In lieu of such compensation, the Surgeon General may, after approval of the Social Security Board, enter into contracts with participating hospitals for the payment of the reasonable cost of hospital service, at rates for each day of hospitalization neither less than the minimum nor more than the maximum applicable rates previously mentioned. Such payments will constitute full reimbursement, the bill provides, for the cost of essential hospital services, including the use of ward or "other least expensive facilities compatible with the proper care of the patient."

PANEL OF PHYSICIANS TO SUPPLY MEDICAL CARE

The Surgeon General will be required to publish and otherwise make known in each area to individuals entitled to benefits the names of general practitioners who have signified their willingness or desire to participate in the insurance program. Any legally qualified physician may so participate. A beneficiary may select any physician appearing on the panel to treat him subject to the consent of the physician selected, and may change such selection in accordance with such rules and regulations as may be prescribed. The Surgeon General may set maximum limits to the number of potential beneficiaries for whom a general practitioner may undertake to furnish medical benefits. Such limits may be nationally uniform or may be adapted to take account of "relevant factors."

The services of specialists will ordinarily be available only on the advice of the general practitioner. The Surgeon General will determine what constitutes specialist services and will also determine the qualifications of physicians as specialists "in accordance with general standards previously prescribed by him after consultation with the council and utilizing standards and certifications developed by competent professional agencies."

PAYMENTS FOR THE SERVICES OF PHYSICIANS

Payments to general practitioners may be made (1) on the basis of fees for services rendered, according to a fee schedule approved by the Surgeon General; or (2) on a per capita basis, the amount being according to the number of individuals entitled to benefits who are on the practitioner's list; or (3) on a salary basis, whole or part time; or (4) on a combination or modification of these bases. The method of payment, subject to the approval of the Surgeon General, will apparently be determined in each area in accordance with the desires of a majority of the general practitioners collaborating with the insurance program.

Payments to designated specialists may include payments on salary (whole time or part time), "per session," fee for service, per capita, or other basis, or combinations thereof. Apparently the method of payment to be adopted for specialists will be determined by the Surgeon General.

Payments for medical services may be nationally uniform or may be adapted to take account of "relevant factors." In any area where payment for the services of a general practitioner is on a per capita basis, the bill provides that the Surgeon General shall distribute on a pro rata basis among the practitioners of the area on the panel those individuals in the area who, after due notice, have failed to select a general practitioner or who, having made a selection, have been refused by the practitioner.

The bill provides that in each area the provision of general medical benefit for all individuals entitled to receive such benefit "shall be a collective responsibility of all qualified general practitioners in the area who have undertaken to furnish such benefit."

LIMITATIONS ON GENERAL MEDICAL AND LABORATORY BENEFIT

The Surgeon General and the Social Security Board may determine for any calendar year or part thereof that every individual entitled to general medical benefit may be required by the physician attending him to pay a fee with respect to the first service or with respect to each service in a "spell of sickness" or course of treatment if it is believed that such a determination is necessary and desirable to prevent or reduce abuses of entitlement ot such benefits. Maximum size of such fee may be fixed by the Surgeon General and the Social Security Board at an amount estimated to be sufficient to prevent or reduce abuses and not such as to impose a substantial financial restraint against proper and needed receipt of medical benefit. Likewise the Surgeon General and the Social Security Board may limit the application of such fees to home calls, office visits or both.

PARTICIPATING HOSPITALS

For a hospital to participate in this insurance program, it must have been approved by the Surgeon General under standards prescribed by him after consultation with the council. A hospital to be approved must provide all necessary and customary hospital services and must be found to afford professional services, personnel and equipment adequate to promote the health and safety of individuals customarily hospitalized in such institution. The Surgeon General may approve or accredit a hospital for limited varieties of cases and may accredit an institution for the care of the "chronic sick." In determining the adequacy of the professional services, personnel and equipment of any such institution, the Surgeon General may take into account the purpose of such limited accrediting, the type and size of community which the institution serves, the availability of other hospital facilities, and such other matters as he may deem relevant.

APPLICATION FOR AND LIMITATION OF HOSPITALIZATION BENEFITS

No application by an individual for hospitalization benefits will be valid with respect to any day of hospitalization if the application is filed more than ninety days after such day, or with respect to any day of hospitalization for mental or nervous disease or for tuberculosis after such diagnosis has been made. The maximum number of days in any benefit year for which any individual may be entitled to hospitalization benefit will be thirty. If, however, the funds in the special hospitalization benefit account fund to be created prove adequate, the maximum number of days may be increased to ninety by the Surgeon General and the Social Security Board, acting jointly.

PROPOSED METHOD OF ADMINISTRATION

The Surgeon General of the Public Health Service will be authorized to take all necessary and practical steps to arrange for the availability of the medical hospitalization and related benefits. He will be authorized to negotiate and periodically to renegotiate agreements or cooperative working arrangements with appropriate agencies of the United States, or of any state or political subdivision thereof, and with other appropriate public agencies, and with private agencies or institutions, and with private persons or groups of persons, to utilize their services and facilities and to pay fair, reasonable and equitable compensation therefor.

The methods of administration, including the methods of payment to practitioners, the bill provides, shall (1) insure the prompt and efficient care of individuals entitled to benefits; (2) promote personal relationships between physician and patient; (3) provide professional and financial incentives for the professional advancement of practitioners, and encourage high standards in the quality of services furnished as benefits through the adequacy of payments to practitioners, assistance in their use of opportunities for postgraduate study, coordination among the services furnished by general practitioners, specialists, laboratory and other auxiliary services, coordination among the services furnished by practitioners, hospitals, health centers, educational, research and other institutions, and between preventive and curative services, and otherwise; (4) aid in the prevention of disease, disability and premature death, and (5) insure the provision of adequate service with the greatest economy consistent with high standards of quality.

NATIONAL ADVISORY MEDICAL AND HOSPITAL COUNCIL

The bill proposes the creation of a National Advisory Medical and Hospital Council, to consist of the Surgeon General of the United States Public Health Service as chairman and sixteen members appointed by him. The appointed members will be selected from panels of names submitted by the professional and other agencies and organizations concerned with medical services and education and with the operation of hospitals and from among other persons, agencies or organizations informed on the need for or provision of medical, hospital or related services and benefits. Appointed members will hold office for four years, with the terms of office staggered. The appointed members will receive compensation at the rate of $25 a day for time spent on official business of the council, and actual and necessary traveling expenses and per diem in lieu of subsistence.

This council will "advise" the Surgeon General as to (1) professional standards of quality to apply to general and special medical benefits; (2) designation of specialists; (3) methods and arrangements to stimulate and encourage the attainment of high standards through coordination of the services of general practitioners, specialists, laboratories and other auxiliary services, and through the coordination of the services of practitioners with those of educational and research institutions hospitals and health centers, and through other useful means; (4) standards to apply to participating hospitals and to establishment and maintenance of the list of participating hospitals; (5) adequate and suitable methods and arrangements of paying for medical and hospital services; (6) studies and surveys of the services furnished by practitioners and hospitals and of the quality and adequacy of such services; (7) grants in-aid for professional education and research projects, and (8) establishment of special advisory, technical, local or regional boards, committees, or commissions.

RELATION TO WORKMEN'S COMPENSATION ACTS

The benefits provided by this bill will not be

available with respect to an injury, disease or disability coming within the purview of any state or federal workmen's compensation act.

The bill devolves on the Surgeon General and the Social Security Board jointly the duty of ascertaining the most effective methods of providing dental, nursing and other needed benefits not contained in the pending bill and of determining the expected costs of such additional benefits. The bill contemplates that the Surgeon General and the Social Security Board will report the results of their findings, with recommendations as to legislation, not later than January 1, 1946.

GRANTS - IN - AID FOR MEDICAL EDUCATION, RESEARCH AND PREVENTION OF DISEASE AND DISABILITY

The Surgeon General will be authorized to administer grants-in-aid to nonprofit institutions and agencies engaging in research or in undergraduate or postgraduate professional education. The purpose of these grants will be to encourage and aid the advancement and dissemination of knowledge and skill in providing benefits and in preventing illness, disability and premature death. Such grants-in-aid will be made with respect to each project (1) for which application has been received from a nonprofit institution or agency, stating the nature of the project and giving the reasons for the need of financial assistance in carrying it out, and (2) for which the Surgeon General finds, with the advice of the council, that the project shows promise of making valuable contributions to the education or training of persons useful to or needed in the furnishing of medical, hospital, disability, rehabilitation and related benefits or to human knowledge with respect to the cause, prevention, mitigation or methods of diagnosis and treatment of disease and disability.

This part of the program will be financed by setting aside a certain percentage of amounts expended for benefits from the Federal Social Insurance Trust Fund to be created by the bill. The amount to be set aside will equal 1 per cent of the total amount expended for benefits from the trust fund, exclusive of unemployment insurance benefits, or 2 per cent of the amount expended for benefits under title IX (relating to federal medical, hospitalization and related benefits), after benefits under that title have been payable for not less than twelve months, whichever is the lesser, in the last preceding fiscal year. The bill apparently leaves all the details with respect to these grants-in-aid to regulations to be promulgated by the Surgeon General after consultation with the council.

SELF-EMPLOYED INDIVIDUALS

Self-employed individuals many receive the benefits of the old age, survivors, and permanent disability and medical and hospital insurance by paying into the Trust Fund an amount equal to 7 per cent of the market value of their services rendered as self-employed individuals, after December 31, 1943, with respect to services in self employment after that date, but not including that part of any remuneration for employment and the market value of services in self employment in excess of $3,000 for any calendar year.

EMPLOYEES OF STATES AND LOCAL SUBDIVISIONS

The bill authorizes the Social Security Board ot enter into compacts with individual states or with political subdivisions for the purpose of extending old age, survivors, and permanent disability and medical and hospitalization insurance coverage to employees of such states or political subdivisions To finance the benefits to be provided under such compacts, the bill requires such employer to pay a social security contribution equal to 3.5 per cent of the wages paid by it after December 31, 1943, and every individual beneficiary of such a compact a contribution equal to 3.5 per cent of the wages received by him after December 31, 1943, excluding any amount paid or received in excess of $3,000 during any calendar year after December 31, 1943. (End of Digest)

COMMENT

The purpose of this bill is to extend the Social Security Law to include Medical and Hospital Services. The proponents claim that it is merely a means of bringing adequate medical care to the lower income groups. The bill has been framed without an iota of advise from a single medical man. There are seven Doctors of Medicine in this Congress of the United States, not one of whom was consulted. It requires but scant study to see that its ramifications are without limit and if passed, the best and most efficient system of medicine in any country on the face of the earth today, would be wiped out in one single stroke. A system which began with the modern era of medicine and evolved through free enterprise, and for the most part, unselfish competition, and founded on the traditional physician-patient relationship, a relationship which cannot exist under such proposal legislation. The Medical profession has been called upon many times in the past for an expression on legislative measures. But all measures in the past, added all together, are mere chicken feed compared to this one. This is a $3,000,000,000 a year kitty to administer the medical care of the entire country, and to be administered by a single man, the Surgeon General. Gentlemen, this is the Jack-pot.

THE USE OF DICUMAROL IN THE PREVENTION OF POST-OPERATIVE PULMONARY EMBOLISM

ROBERT S. FLINN
Phoenix, Arizona

DICUMAROL, an extract of spoiled sweet clover, was first isolated and later synthesized by Professor Link of the University of Wisconsin. This substance has been shown to increase the prothrombin time definitely when given to human beings. There is good experimental evidence to indicate that the prolongation of the prothrombin time will inhibit intravascular thrombosis. Bollman, Dale and others have shown that dicumarol decreases the tendency to thrombosis in veins and arteries in experimental animals. The effect is apparently the result of suppression of the formation of the prothrombin. Secondary effects are interference with normal clot retraction and increased sedimentation rate.

Barker, Allen and Waugh recommend an initial single dose of 300 milligrams for the first day and 200 milligrams the second day. On the third day, daily determinations of the prothrombin time are begun and 200 milligrams of dicumarol are given on each day that the prothrombin time is less than 35 seconds. The prothrombin time should be kept between 35 to 60 seconds. When dicumarol is discontinued the prothrombin time remains elevated from three to seven days and gradually turns to normal. However, the effects of the dicumarol can be quickly abolished by the use of a transfusion with freshly drawn blood.

In cases of postoperative pulmonary embolism or postoperative thrombophlebitis the administration of dicumarol is begun as soon as the diagnosis is made. As a prophylaxis against thrombosis in postoperative patients dicumarol is given the day following operation and the prothrombin time is kept elevated for ten days or more until the patient is up and about.

INDICATIONS

Individuals who have had one attack of pulmonary embolism after an operation or those who have had postoperative thrombophlebitis should be treated with dicumarol, since the statistical study of Nygaard, Walters and Priestly have shown that these patients are especially vulnerable and may develop a fatal pulmonary embolism.

Individuals who have had thrombophlebitis or pulmonary embolism six months prior to operation may also be considered candidates for postoperative pulmonary complications and should be treated with dicumarol.

CONTRAINDICATIONS

Dicumarol should not be used for patients who are bleeding. This is particularly true in subacute bacterial endocarditis, renal insufficiency, and purpura of any type. Hepatic disease, jaundice and malnutrition are also contraindications.

REPORT OF A CASE

On March 27th, 1943 a 50 year old obese individual with mild myocardial disability and prostatic obstruction was admitted to St. Joseph's Hospital with urinary retention. Because of an indwelling catheter his movements were markedly restricted and he developed a phlebothrombosis of the right leg and suffered two moderately severe attacks of pulmonary embolism, with shock, dyspnea, pallor, low blood pressure and characteristic electrocardiographic findings. With the aid of atropine and papaverine intravenously the patient survived these attacks.

Because statistical studies indicate that a patient who has had even a mild attack of pulmonary embolism has a slightly less than 1 chance in 5 of having a subsequent fatal pulmonary embolism, it was decided to treat this patient with dicumarol. Through the courtesy of the Abbott Laboratories a supply of dicumarol was obtained and the patient was given 300 milligrams one day prior to operation and thereafter received 200 milligrams daily until the eighth postoperative day. Daily prothrombin levels varied from 35 to 45 seconds. The prothrombin time returned to normal eight days following discontinuance of the drug. A transurethral resection was performed by Dr.

(Balance of Paper and Summary Continued on Page 24)

Read before the staff of St. Joseph's Hospital, Phoenix, Arizona, October 15th, 1943.

ARIZONA MEDICINE

Journal of
ARIZONA STATE MEDICAL ASSOCIATION

Vol. 1, No. 1 January-February, 1944 $1.25 per year

EDITOR
Frank J. Milloy, M. D. ..... Professional Bldg., Phoenix

ASSOCIATE EDITORS
J. D. Hamer, M. D. ..... Phoenix
D. F. Harbridge, M. D. ..... Phoenix

ADVERTISING and SUBSCRIPTION OFFICES
A. C. Taylor Printing Company
142 South Central Avenue
Phoenix, Arizona

Eastern Representative:
Cooperative Medical Advertising Bureau
535 N. Dearborn St., Chicago

Editorials

The Birth of Arizona Medicine

With this issue *Arizona Medicine*, as official publication of the Arizona Medical Association, makes its debut among the medical journals of the other states of the nation. When the governors of Southwestern Medicine found it necessary to discontinue the publication of Southwestern Medicine for the duration, the Council of the State Society took the opportunity to publish a journal devoted entirely to the State of Arizona. While we regret deeply the loss of our many friends in New Mexico and El Paso, nevertheless the members of the State Medical Profession have long felt the need and necessity of its own journal. Arizona Medicine will be published bi-monthly. An attempt will be made to reach all the physicians of the State who are in the armed forces. The curtailment of the Scientific Meetings of the State Society will hamper to some degree, the securing of material for the pages of the journal. A letter has been written to as many of the members in the armed forces as we had addresses for, asking them for either a personal letter, or an account of their medical experiences to whatever extent they would be permitted to reveal them. As this first issue goes to press we have had little response so far. The problems of medical care have become such a major subject of discussion that there is scarcely an election, or a meeting of the National Congress, or the State Legislatures, that new medical legislation is proposed. It will be the policy of the Editorial Staff to keep the members of the State Society as fully informed as possible on the advent, and progress of such legislations. The comments and criticisms of the members of the State Society will be welcomed.

Whither—Organized Medicine

It is an honor and a pleasure to contribute an editorial for this, the first issue of *Arizona Medicine*. The Editor, in extending his kind invitation for the contribution, left open the choice of subject. Being mindful of the increasing attempts to overthrow the practice and service of medicine as it has always been understood and heartily accepted, and being mindful of the pernicious ramifications of such current mal-legislation as the Wagner Bill (Senate 1161), I know of nothing better that I can say than to sound a warning on "Whither—organized medicine."

It so happens that my presidential address, when I was inducted into that high office of our association in 1940, covered the subject with what I said then as appropriate today, if not more so, than when presented then. I, therefore, repeat brief sections of that article for editorial thought here:

SOUNDING OFF

There are those sitting in high places who are sounding a discordant note against organized medicine. This discordant note has to do with medical service rather than with medical practice—and medical service at a price, the price being restriction and regimentation. Sounding this sour note are the economist and the sociologist who have arrived on the American scene and in the medical field. They are implemented by propagandists. By their activities they have diminished, and in some instances almost destroyed the faith of the public in the medical leadership which accomplished so much for the public welfare before the arrival of the expert economist and the expert sociologist. Their fascinating theories, couched in cleverly formed phrases and uttered in well-cultivated voices make a stronger appeal, in many instances, than the calm, logical voice of experienced medicine.

THE ECONOMIST PROPOSES

The economist forgets, or ignores, that the man of medicine is not trained to work for

money. The medical student is taught from the outset that he is not to work for money or to work for fame, but to search for knowledge and to seek to relieve the suffering of mankind. If the economist has his way and continues to seek a service at a price, he will soon find himself in the position of the family employing a Chinese cook. In employing this Chinese cook the question of salary arose. "What do you charge for your cooking, Ying?" asked the lady of the house. "What kind of cooking you wantee?" countered Ying. "Me do $20 cooking, or me do $10 cooking." The physician, if permitted to continue with his private practice, will give his patients, as always, good, substantial $20 cooking, but if hired to serve medicine at a price is very apt to lag into indifferent $10 cooking. If profit is to be removed from medicine, physicians will at best become draft animals. If the question of gain is to be removed from medicine and the general public taxed so that those not having medical care may have it, then why not sell automobiles at cost and levy a tax on the public so that those not able to buy automobiles even at cost may have them free. One proposition is as reasonable as the other in the final analysis.

A socialized medicine is being proposed in place of an organized medicine. Organized medicine has its roots in democracy, for "Wherever the art of medicine is found, there also is found a love for humanity." Socialized medicine does not have its roots in the democratic principles which have made this country great, for it would destroy individual initiative. It is true that government must assume its rightful responsibility for the care of those on welfare rolls, but there must be a limit beyond which government must not step without usurping personal responsibility. Government's first problem in medical service is to provide adequate care for those on relief; its second consideration is to permit the medical profession and organization to till its own field. "Medical problems can best be solved by medical practitioners, not by ambitious, if well informed, politicians who never circumcised a young man nor catherized an old one." Our changing medical service can and must be changed only by the physician himself, through his medical society, and not through regimentation. The medical practitioner must be free from bureaucratic control in order that he may go his untrammeled way in adding his mite to the beneficient influence which our profession has always contributed to the upward progress of humanity.

ORGANIZED MEDICINE DISPOSES

If American medicine is to be saved from disaster, it must be through organized medicine, and the individual physician must be prepared to play his part or take the consequences. Propaganda can be met only by counter-propaganda. Half truths, illogical deductions, insidious innuendoes, and their like, can only be met by refutations and counter-activities that give the lie to them.

In this, our medical organization in Arizona, the responsibilities do not rest entirely with the officers of your association. *In the last analysis, the rank and file of the membership are the ones responsible.* They should make it their business to take an active constructive part in the affairs of the association, keep themselves thoroughly and fully informed on the social and political problems and be prepared to meet them intelligently.

If each individual physician will do his full part, both as a private practitioner of medicine and as a member of his professional guild, our case will rest pretty largely in the hands of our patients and ourselves and there will be little to fear as to the outcome. A great deal has been accomplished in recent years through our organizations, county, state and national, but a great deal more can and must be done if we are to hold our ground in this modern changing society. —*D. F. Harbridge, M. D.*

National Physicians Committee

While most every physician in the country has heard of the National Physicians Committee and many have received literature from this organization, not every one is familiar with the exact status of this organization and the work it is performing. This Committee was organized 4 years ago. Its chairman is Dr. Edward H. Cary of Dallas, Texas, a former president of the American Medical Association. The Board of Trustees consist of names of nationally known physicians from Coast to Coast. In brief, this Committee was organized to de-

termine what and when and where the private practice of medicine is failing to render the best medical care to the American public, and if possible to find the answer to these deficiencies. It is also the purpose of this Committee to carry on an Educational Campaign to the public, to acquaint them with the best way to derive efficient and proper medical care. In performing this latter service, they are conducting the equivalent of a Gallup Poll among the American public, the results of which will be available early in 1944. Another major function of this Committee is to combat National Legislation which is considered detrimental to the American system of private medical practice. So their greatest problem at this time is to assure defeat of the Murray-Wagner Bill before Congress. The following resolutions clarify the status of the National Physicians Committee with the American Medical Association.

On June 9th, in Atlantic City, the House of Delegates of the American Medical Association adopted a resolution of endorsement of the National Physicians Committee. The Resolution reads:

"BE IT RESOLVED; that we register our approval of the activities of the National Physicians Committee for the Extension of Medical Service, commend the Board of Trustees and the Management of this institution for the efforts they have made to enlighten the general public in connection with American Medicine's methods, progress and achievements and in pointing out that the public has a vital interest in the final result; and

"BE IT FURTHER RESOLVED that it be declared the policy of this House of Delegates to encourage this effort and similar efforts with identical purposes."

COUNCIL ON MEDICAL SERVICE AND PUBLIC RELATIONS ENDORSES

The annual meeting of the AMA House of Delegates—Chicago, June 7-10, 1943—by formal action established a Council on Medical Service and Public Relations. Subsequently the Council defined general policies. Clause 7 of A Statement of General Policies (of the Council) reads:

"There is no official affiliation between the American Medical Association and the National Physicians Committee. However, since it is the purpose of the National Physicians Committee to enlighten the public concerning contributions which American medicine has made and is making in behalf of the individual and the nation as a whole, *it is the opinion of the Council that the medical profession may well support the activities of the National Physicians Committee* and other organizations of like aims."

This Committee is financed by voluntary subscriptions from physicians throughout the country. During the past year of 1943, 6227 physicians have contributed, which included 25 from Arizona. In recognition of the work being done by the Committee, the Maricopa County Medical Society in executive session voted unanimously to levy a special assessment of $10 per member to be added to the regular 1944 dues, and the proceeds to be forwarded to the Treasurer of the organization. There are approximately 120 members of the Maricopa County Medical Society, not including those in Military Service.

Office of Civilian Defense

The following news item has been released by the office of Civilian Defense Ninth Civilian Region, San Francisco, California.

San Francisco—Dec. 9, 1943—The Office of Civilian Defense announced today that 40 out of the planned 50 "Affiliated Base Hospital Units and Surgical Teams" sponsored by hospitals and medical schools in California, Nevada, Arizona, Washington, Oregon, Utah, Idaho, and Montana have been completed. These "Units" are formed by civilian physicians and dentists and will be available to either OCD or the Army in the event of the necessity of emergency medical needs in their respective areas.

Each "Unit" is composed of 15 members or less, according to the availability of physicians, surgeons, and specialists in various localities. They will be called upon by the War Department only in the case of extraordinary military necessity requiring hospital and medical care beyond the immediate facilities of the Army in any particular locality.

OCD will use these Units and Surgical Teams to supplement the staffs of "Emergency Base Hospitals" located in relatively safe zones near critical areas should it become necessary to evacuate civilian patients from these critical areas.

Physicians accepted for service in the Units receive commissions in the Reserve of the U. S. Public Health Service but will not be called to active duty by the Surgeon General (USPHS) except at the request of OCD, through the respective State Chiefs of Emergency Medical Service. When a unit is needed, the physicians of the Unit will be placed on active duty only for the duration of a particular emergency in order to prevent further depletion of the civilian doctors.

The Affiliated Units in the Western area are divided as follows: California; Los Angeles, 8; Pasadena, 1; San Diego, 1; San Bernardino, 1; Ventura, 1; Santa Barbara, 1; San Francisco, 5; Oakland, 2; Santa Rosa, 1; San Jose, 1; Salinas, 1; Stockton, 1; Fresno, 1; Bakersfield, 1. Oregon: Portland, 4; Salem, 1; Eugene, 1. Washington: Seattle, 3; Spokane, 3; Tacoma, 2; Bellingham, 1; Everett, 1; Wenatchee, 2 teams; Yakima, 1 team. Idaho: Boise, 1. Montana: Great Falls, 1. Utah: Ogden, 1. Nevada: Reno, 1. Arizona: Phoenix, 1.

The Phoenix Unit has been organized at St. Joseph's Hospital consisting of fifteen members of the staff all of whom have been accepted and approved by the Regional Civilian Defense Office and have been recommended for Reserve Commissions to the U. S. Public Health Department, Washington, D. C.

The U. S. Office of Civilian Defense today announced that 93 hospitals and medical schools scattered throughout the country have completed formation of "affiliated units" of civilian physicians which will be available to either OCD or the Army in the event of need for setting up emergency hospital facilities in their respective areas.

Each unit is composed of 15 physicians, surgeons and other specialists, and forms a balanced professional staff. OCD will use the units to supplement the staffs of "emergency base hospitals" located in relatively safe zones on the fringes of critical areas in case it is necessary to transfer civilian patients to these hospitals because of emergency in such areas.

The units will be called upon by the War Department to staff extemporized hospitals should there be a sudden influx of battle front casualties, or some other extraordinary military necessity, requiring hospitals and physicians beyond the immediate capacity of the Army in any particular locality.

The OCD-affiliated units will be used for military emergency purposes only in or near the communities in which the staff resides. Their duty will be temporary and they will be replaced by Army doctors as quickly as the Surgeon General of the Army can make the necessary assignments.

Normally, all the 15 doctors of a unit are associated with a single hospital. Each unit includes: a chief and assistant chief of medical services, two general internists, a chief and assistant chief of surgical services, four general surgeons, two orthopedic surgeons, one dental surgeon, one pathologist, and one radiologist.

Physicians accepted for service in the units receive inactive reserve commissions in the U. S. Public Health Service, but will be called to active duty by the Surgeon General (USPHS) only at the request of OCD. When a unit is needed, either to staff an emergency base hospital or to assist the Army temporarily in a military emergency, the physicians of the unit will be placed on active duty for the duration of that particular emergency.

Organization of these units in selected communities will give both OCD and the Army organized emergency hospital staffs which can be called upon in time of need.

THE USE OF DICUMAROL IN THE PREVENTION OF POST-OPERATIVE PULMONARY EMBOLISM

(Continued from Page 20)

John W. Pennington and the patient's recovery was quite straightforward.

SUMMARY

Dicumarol is effective when given by mouth and is capable of prolonging the prothrombin time. There is adequate experimental and clinical evidence to indicate that it is effective in preventing postoperative thrombophlebitis and pulmonary embolism. It should not be given unless the protrombin time can be determined accurately daily. There is some slight risk in postoperative bleeding but this can be controlled by transfusions.

BIBLIOGRAPHY

Barker, N. W., Allen, E. V., and Waugh, J. M., proc. Staff meeting, Mayo Clinic, 18, 102-107, April 7, 1943.

Ibid J.A.M.A. 120:13, 1009-1015, Nov. 28, 1942.

Wright, I. S., and Prandoni, A., J.A.M.A. 120:13, 1015-1021, Nov. 28, 1942.

ORGANIZATION SECTION

CONFERENCE OF WESTERN MEDICAL ASSOCIATIONS

On December 11, the Western State Medical Associations convened at Salt Lake City, holding the conference at the Hotel Utah. A preliminary conference had been held at San Francisco on November 2 which was attended by our President, Dr. O. E. Utzinger. Dr. Utzinger was unable to get away for the second conference; so, as Chairman of the Committee on Public Policy and Legislation, the undersigned attended.

Action of the conference was based largely on an exhaustive report presented by Mr. Ben Read, Executive Secretary of the California Public Health League which is one of the legislative media for the California Medical Association. Mr. Read had been sent by the California Medical Association to Washington for a month to learn first hand advisable legislative procedures for the medical profession. Mr. Read returned from Washington on December 7, hence his report was based on latest findings and developments.

Business Before the Conference

Dr. Dwight H. Murray, Chairman of the Committee on Public Policy and Legislation of the California Medical Association, opened the meeting stating there were something like three important questions before this conference: there was the question of how to go about combatting or supporting legislation pending in the Halls of Congress; the question of what the American Medical Association could be counted on to do, and the question of whether the 11 western states desire to get together as a bloc in order to secure the 'ear' of Congress. Dr. Murray stated that Mr. Ben Read had been sent by the California Medical Association for a month's investigation at Washington and that he was charged with securing answers to three specific questions: 1. What does the Congress think of doctors of medicine? 2. What does the Congress think of the American Medical Association as an organization? and, 3. should a Medical Information Bureau be established at Washington?

Washington Attitude

Mr. Read then took the floor and for two full hours addressed the conference on his findings at Washington. In Washington, Mr. Read held extensive interviews with the 7 physicians who are members of the Congress, with leading members of the Senate and House. He also held conferences with heads of the Bureaus of Information of the American Dental Association, the National Retail Druggists Association, the American Hospital Association, with the Osteopaths and Chiropractors and numerous other individuals, boards and agencies set-up for legislative purposes.

The Wagner Bill

Before going into the replies he had ready on the three specific questions he had been charged to find answers for, Mr. Read stated that the Wagner Bill, in which all held a deep interest, had little chance of coming out for vote this spring but that there was much agitation for it. He stated further that the SOCIAL SECURITY ACT WILL BE ENLARGED THROUGH VARIOUS SCHEMES UNDER THE NAME OF *WELFARE* AND THAT FUNDS WILL BE PROVIDED FOR FURTHER ENCROACHMENT ON THE PRIVATE PRACTICE OF MEDICINE. Mr. Read emphasized that all activity for or against any measure must be made while that bill is in committee for once it hits the floor of Congress there is little to be done to secure revision or amendment.

What Does the Congress Think of Doctors of Medicine?

From his interviews Mr. Read stated that the Congress, and the various other individuals and organizations he interviewed, were fully sympathetic with the position of the individual physician and that the doctor, as such, could be heard in the Congress.

What Does the Congress Think of the AMA?

Mr. Read reported that from all his interviews at Washington he must report that the attitudes toward some representatives of the AMA were not sympathetic and not cordial. The AMA has no information bureau at Wash-

ington; it opposes all legislation yet offers nothing but criticism in return.

Should a Medical Information Bureau be Established in Washington?

The reply to the question of establishing a Medical Information Bureau at Washington was unanimously 'yes'. From all sides, and from congressmen in particular, came the complaint that they had no source to which they could go for information needed in regard to health legislation. The Executive Secretary of the Medical Society of the District of Columbia stated that because their Society was located there in the city of Washington they were swamped with questions pertaining to legislation on which they did not have, and could not have, information—such questions were: How many indigent children were there in Arkansas last year; How much is California spending for Social Security? One congressman stated there must be such a Bureau established to answer the 1,000 and 1 questions arising daily in connection with health legislation. The American Dental Association and the American Hospital Association have long maintained such bureaus at Washington where information relating to their professions may be had for the asking. The Medical profession has never been so represented in Washington. Mr. Read brought back with him a Telephone Directory of the city of Washington and thumbed through the pages of Bureaus of Information listed therein.

The Wagner Bill Again

Mr. Read learned that the American Dental Association was opposed to the Wagner Bill and believes that their organization and the medical organizations should get together on health legislation. Much opposition was found against the bill from the various individuals interviewed. The osteopaths are also opposed to the bill and it was the suggestion of one congressman that the medical profession secure the support of the osteopaths in as much legislation as possible as the osteopaths have considerable strength especially in the Senate. The only organization found in support of the Wagner Bill was the CIO.

A War Service Bureau

It was recommended to Mr. Read that he bring back the suggestion to his group that the American Medical Association immediately establish a War Service Bureau at Washington as there will be at least 100,000 new war patients in government hospitals before the close of this year and that the Congress must have an immediate source at Washington where they may have the first-hand information for needs arising for such hospitalization purposes.

Action of the Conference

When Mr. Read concluded his address, (and I should state here that all his interviews at Washington were by way of dictograph records and that he read the verbatim comments of those whom he interviewed as well as his own remarks and questions frequently throughout his report), Dr. Murray took the floor and brought the business of the conference to a head by means of four motions:

*1. To poll the states at this meeting for a vote as to advisability of forming a bloc of the 11 Western States for the purposes of sponsoring a Medical Information Bureau at Washington.
2. Authorized appointment of a committee to draw up Resolutions as to the purposes and aims of this group.
3. That a Committee draw up the framework for a permanent organization of this group.
4. That officers for this Conference Committee be named, Dr. Dwight H. Murray being named the permanent chairman.

After a 30 minute recess, the Resolutions Committee presented their report which was adopted. It was voted that copies of these Resolutions be sent to: the Secretaries of the 11 Western States for the consideration of their Councils; to the secretaries of all state medical associations; to the American Medical Association and to the National Physicians Committee. It was also voted that a condensed report from Mr. Ben Read, together with the Minutes of this Conference should also be mailed the same organizations.

Before closing this report I should state that Mr. Read reported that those he interviewed were critical of the National Physicians' Committee, stating that the publicity sponsored by this Committee had been effective against the Wagner Bill but questionable in some other instances. The National Physicians' Committee can not be expected to aid in legislative matters

as their function is that of education and that under their present set-up they are not in position to get the legislative job done at Washington. It was suggested by a former member of the Board of that Committee, who was in attendance at the Salt Lake Conference as a representative from his state society, that the NPC might tie up with the medical profession in setting up a Medical Informaion Bureau at Washington.

Conclusions

Dr. Murray concluded the conference by expressing appreciation for the keen interest of the western associations. He said that the conference had now acted by endorsing some Resolutions of prime importance but that the Conference would now have to await the action of the Councils of the 11 Western Medical Associations before it could proceed with its further business.

Council of Arizona Medical Association

As soon as the Resolutions are officially received, which will be in the immediate future, President Utzinger will convene the Council of the Arizona Medical Association and secure immediate action on the matters presented. This may even be before this Journal goes to press, in which case a 'Flash Report' will be found elsewhere in these pages. In any event all county medical societies, and the membership, will be informed as soon as our Council receives and acts upon the recommendations of the Conference herein reported.

Signed,

Jesse D. Hamer, M. D., Chairman,
Committee on Public Policy and
Legislation.

*The poll found the Conference unanimous in favor of establishing such a Bureau and Resolutions were adopted accordingly and will be submitted each Council for its vote.

NOTE: A second conference at Salt Lake is set for January 29, our Council to take formal action thereafter.

ANNUAL CONFERENCE OF SECRETARIES AND EDITORS OF CONSTITUENT STATE MEDICAL ASSOCIATIONS

The Annual Conference of Secretaries and Editors of Constituent State Medical Associations was held at the AMA Headquarters in Chicago, November 19-20. Before this notice appears in Arizona Medicine, the entire proceedings will probably have been published in the Journal of the American Medical Association. While the entire discussion of the meeting should be of interest to everyone, because every subject discussed affects the present and future status of every medical man in this country, you are particularly urged to read and study the work of the Council on Medical Service and Public Relations, whose chairman is Dr. Louis H. Bauer; and the subject of medical legislation in Congress as presented by J. W. Holloway, Jr., Director of the Bureau of Legal Medicine and Legislation of the American Medical Association.

The trend of the times was evidenced by the fact that at the Meeting last year about 80 per cent of the discussion was devoted to the military needs of the armed forces and to the Procurement and Assignment of Physicians, and the balance to proposed legislation and civilian needs; the reverse was true this year. Practically the entire meeting was devoted to post-war thinking and proposed legislation in Congress.

To summarize briefly: The Directors of the Procurement and Assignment bestowed the highest praise on the various state chairmen of this service.

The Armed Forces placed their original requirement at 62,000 medical officers. This has been reduced to 48,000—at the present time there are about 41,000—so that 7 thousand more are needed. At the present time it so happens that the military authorities are discharging about as many doctors, due to physicial unfitness and inability to withstand army routine, as they are inducting. But they still hope to reach the revised program of 48,000.

An item of interest here is that the military decided to give women physicians commissions, hoping to enlist between 500 and 600. So far 38 have volunteered.

I am urging everyone to read the article presented by Dr. Louis H. Bauer, Chairman of the Council on Medical Service and Public Relations. This Council was created at the Meeting of the House of Delegates in June of this year. It has just secured the services of a permanent secretary, Dr. Kelly, former Dean of Medicine, University of Georgia. It is the intended and proposed function of this Council to bring all information concerning medical legislation in the National Capitol, progress on all economic problems confronting the medical pro-

ington; it opposes all legislation yet offers nothing but criticism in return.

Should a Medical Information Bureau be Established in Washington?

The reply to the question of establishing a Medical Information Bureau at Washington was unanimously 'yes'. From all sides, and from congressmen in particular, came the complaint that they had no source to which they could go for information needed in regard to health legislation. The Executive Secretary of the Medical Society of the District of Columbia stated that because their Society was located there in the city of Washington they were swamped with questions pertaining to legislation on which they did not have, and could not have, information—such questions were: How many indigent children were there in Arkansas last year; How much is California spending for Social Security? One congressman stated there must be such a Bureau established to answer the 1,000 and 1 questions arising daily in connection with health legislation. The American Dental Association and the American Hospital Association have long maintained such bureaus at Washington where information relating to their professions may be had for the asking. The Medical profession has never been so represented in Washington. Mr. Read brought back with him a Telephone Directory of the city of Washington and thumbed through the pages of Bureaus of Information listed therein.

The Wagner Bill Again

Mr. Read learned that the American Dental Association was opposed to the Wagner Bill and believes that their organization and the medical organizations should get together on health legislation. Much opposition was found against the bill from the various individuals interviewed. The osteopaths are also opposed to the bill and it was the suggestion of one congressman that the medical profession secure the support of the osteopaths in as much legislation as possible as the osteopaths have considerable strength especially in the Senate. The only organization found in support of the Wagner Bill was the CIO.

A War Service Bureau

It was recommended to Mr. Read that he bring back the suggestion to his group that the American Medical Association immediately establish a War Service Bureau at Washington as there will be at least 100,000 new war patients in government hospitals before the close of this year and that the Congress must have an immediate source at Washington where they may have the first-hand information for needs arising for such hospitalization purposes.

Action of the Conference

When Mr. Read concluded his address, (and I should state here that all his interviews at Washington were by way of dictograph records and that he read the verbatim comments of those whom he interviewed as well as his own remarks and questions frequently throughout his report), Dr. Murray took the floor and brought the business of the conference to a head by means of four motions:

*1. To poll the states at this meeting for a vote as to advisability of forming a bloc of the 11 Western States for the purposes of sponsoring a Medical Information Bureau at Washington.
2. Authorized appointment of a committee to draw up Resolutions as to the purposes and aims of this group.
3. That a Committee draw up the framework for a permanent organization of this group.
4. That officers for this Conference Committee be named, Dr. Dwight H. Murray being named the permanent chairman.

After a 30 minute recess, the Resolutions Committee presented their report which was adopted. It was voted that copies of these Resolutions be sent to: the Secretaries of the 11 Western States for the consideration of their Councils; to the secretaries of all state medical associations; to the American Medical Association and to the National Physicians Committee. It was also voted that a condensed report from Mr. Ben Read, together with the Minutes of this Conference should also be mailed the same organizations.

Before closing this report I should state that Mr. Read reported that those he interviewed were critical of the National Physicians' Committee, stating that the publicity sponsored by this Committee had been effective against the Wagner Bill but questionable in some other instances. The National Physicians' Committee can not be expected to aid in legislative matters

as their function is that of education and that under their present set-up they are not in position to get the legislative job done at Washington. It was suggested by a former member of the Board of that Committee, who was in attendance at the Salt Lake Conference as a representative from his state society, that the NPC might tie up with the medical profession in setting up a Medical Informaion Bureau at Washington.

Conclusions

Dr. Murray concluded the conference by expressing appreciation for the keen interest of the western associations. He said that the conference had now acted by endorsing some Resolutions of prime importance but that the Conference would now have to await the action of the Councils of the 11 Western Medical Associations before it could proceed with its further business.

Council of Arizona Medical Association

As soon as the Resolutions are officially received, which will be in the immediate future, President Utzinger will convene the Council of the Arizona Medical Association and secure immediate action on the matters presented. This may even be before this Journal goes to press, in which case a 'Flash Report' will be found elsewhere in these pages. In any event all county medical societies, and the membership, will be informed as soon as our Council receives and acts upon the recommendations of the Conference herein reported.

Signed,

Jesse D. Hamer, M. D., Chairman,
Committee on Public Policy and
Legislation.

*The poll found the Conference unanimous in favor of establishing such a Bureau and Resolutions were adopted accordingly and will be submitted each Council for its vote.

NOTE: A second conference at Salt Lake is set for January 29, our Council to take formal action thereafter.

ANNUAL CONFERENCE OF SECRETARIES AND EDITORS OF CONSTITUENT STATE MEDICAL ASSOCIATIONS

The Annual Conference of Secretaries and Editors of Constituent State Medical Associations was held at the AMA Headquarters in Chicago, November 19-20. Before this notice appears in Arizona Medicine, the entire proceedings will probably have been published in the Journal of the American Medical Association. While the entire discussion of the meeting should be of interest to everyone, because every subject discussed affects the present and future status of every medical man in this country, you are particularly urged to read and study the work of the Council on Medical Service and Public Relations, whose chairman is Dr. Louis H. Bauer; and the subject of medical legislation in Congress as presented by J. W. Holloway, Jr., Director of the Bureau of Legal Medicine and Legislation of the American Medical Association.

The trend of the times was evidenced by the fact that at the Meeting last year about 80 per cent of the discussion was devoted to the military needs of the armed forces and to the Procurement and Assignment of Physicians, and the balance to proposed legislation and civilian needs; the reverse was true this year. Practically the entire meeting was devoted to post-war thinking and proposed legislation in Congress.

To summarize briefly: The Directors of the Procurement and Assignment bestowed the highest praise on the various state chairmen of this service.

The Armed Forces placed their original requirement at 62,000 medical officers. This has been reduced to 48,000—at the present time there are about 41,000—so that 7 thousand more are needed. At the present time it so happens that the military authorities are discharging about as many doctors, due to physicial unfitness and inability to withstand army routine, as they are inducting. But they still hope to reach the revised program of 48,000.

An item of interest here is that the military decided to give women physicians commissions, hoping to enlist between 500 and 600. So far 38 have volunteered.

I am urging everyone to read the article presented by Dr. Louis H. Bauer, Chairman of the Council on Medical Service and Public Relations. This Council was created at the Meeting of the House of Delegates in June of this year. It has just secured the services of a permanent secretary, Dr. Kelly, former Dean of Medicine, University of Georgia. It is the intended and proposed function of this Council to bring all information concerning medical legislation in the National Capitol, progress on all economic problems confronting the medical pro-

fession, and the results and successes of the various Voluntary Health Insurance plans in operation, to the constituent medical societies throughout the nation. If success is to be attained in defeating national legislation unfavorable to good medical service, and the private practice of medicine, an intensive educational program for the public must be carried on, and the county medical society is the bureau through which the public is to be reached. The opponents of medicine have been selling the public the information that something is wrong with the system. This must be corrected. As things now stand, the public is not aware of what the American Medical Association stands for.

The discussion on the Obstetric and Pediatric care for the Wives and Children of Servicemen was the most spirited and exciting of the Conference. Don't miss any of it.

Much thought has been given in the past year to the rehabilitation of the possible number of 40,000 physicians to be demobilized when the war ends. Of these, it is estimated that 20,000 or ½ have never been established in privated practice. These are the ones who need planning for.

Respectfully submitted,

Frank J. Milloy, Secretary

ATTENTION, ALL PHYSICIANS

The War Man Power Commission issued a new Employment Program which became effective the morning of October 16, 1943.

Section 7, paragraph (4a) states, "When an applicant for a statement of availability alleges that his migration is necessary because of the health of himself or immediate members of his family, he shall obtain from a competent medical authority showing the following:

(a) The physical or pathological condition requiring migration from the job area.

(b) Altitude, climatic or other conditions required for patient, and

(c) The number and extent of examinations, observations or consultations upon which certification is made."

"The granting of a statement of availability based on such a medical statement is subject to appeal and the doctor's statement shall not be deemed conclusive of the necessity for such migration. Conflicting opinions may, if requested, be referred for determination of the dispute to an appropriate medical officer of the U. S. Public Health Service."

With the government asking for more and more essential war production, there has been an increasing migration of workers from the mines of Arizona to other defense projects. Many of these workers have left their employment armed with a certificate from a physician stating that they or a member of their family would enjoy improved health in another locality. One physician reported that in one day he refused certificates to three workers and later found all of them had obtained jobs in other states, due to the fact that they had certificates from other physicians. This is a very serious situation and we ask that all doctors give the most careful consideration to ease request for a transfer, making sure that conditions of health are the real reason for the request, rather than that the one making such request is trying to use the profession as a means of obtaining more lucrative employment elsewhere. Already cases are being reviewed by the Public Health Service. Let us do all we can to aid to the utmost the fullest production of essential war materials in Arizona. O. E. Utzinger

---

SALT RIVER VALLEY BLOOD BANK

Before the Pearl Harbor disaster, there were few physicians and even fewer civilians who realized the meaning of a blood bank. It takes the urgent necessity of a major catastrophe to point the way to new methods of treatment and valuable aids in the handling of emergencies.

The importance of transfusions in the treatment of many diseases has been recognized for many years and has been in general use following the discoveries of the so-called A and B substances in the blood by Lansteiner in 1900, of simple methods of typing by Jansky in 1907 and Moss in 1910, and of the use of citrate for the prevention of blood clotting by Huestin in 1914.

But in spite of the fact that the value of plasma was recognized for the treatment of shock in 1918 by Ward, its general use for this purpose did not come into prominence until the beginning of the present world war. It is now well established that plasma is essential for the treatment of surgical shock from burns and other causes and, in an emergency, can

temporarily take the place of whole blood in replacing blood lost from hemorrhage. It has the great advantage over whole blood that when properly pooled, typing of the patient is unnecessary and when dried or frozen, it will keep indefinitely.

About two years ago, the Maricopa County Medical Association felt that because of the size of this community, because of the difficulty of obtaining blood in adequate amounts at a moment's notice, and because of th eneed of plasma not only for civilian use but also for the military hosptials in this area, a blood bank should be established.

At a meeting, it was therefore voted by the members that the Maricopa County Medical Society would sponsor a blood bank and that it would elect three of its members to act on the Executive Committee of the Blood Bank and that these members in turn would elect a member of the Medical Auxiliary and a lawyer to make up the five members of the Executive Committee, the function of this body being to direct all the policies and attend to all the work necessary for the establishment of this organization.

Over a period of several months, the necessary money was raised by private contribution, from individuals, and from business concerns, as well as from the United War Fund. Money was also advanced by the County as a deposit against the withdrawal of blood and plasma in the treatment of the county poor. With this capital, the necessary architectural changes were made in the east wing of the Social Service Center, generously donated to house the Bank, the actual labor and most of the materials having been also donated. After a certain number of priority difficulties, the Salt River Valley Blood Bank was finally opened for operation on October 4, 1943.

The permanent staff consists of a full-time supervisor who is a graduate nurse, another full-time graduate nurse who lives on the premises, a full-time laboratory technician, and a full-time doctor who is also trained in laboratory work. At the outset, a part-time physician came in to supervise the drawing of the blood two afternoons and two mornings a week but when she was taken ill, the physician from the laboratory and the two nurses found that they could adequately carry on the bleeding program. Added to this full-time staff, there is a corps of about seventy faithful, hard-working volunteers without whom the Bank could not exist; their duties are manifold ranging from making donor appointments, registering the donors, operating a telephone switchboard, doing typewriting and bookkeeping, acting as hostesses and nurses' aides, transporting the blood, rounding up, registering, and typing individuals who cannot be donors, giving the resident nurse relief periods, since the Bank has to be ready to receive calls twenty-four hours a day, providing the homemade cookies and the beverages for the donors. It is to be noted that, in its operation, the Bank follows the strictest O.C.D. technique.

In order that the Bank may eventually be self-supporting, a service charge of $7.50 is made for each pint of blood and $10.00 for each unit of plasma, or half pint of plasma, plus a donor in each case. In order that the patients may feel their responsibility in keeping the shelves of the Bank supplied with blood, they are temporarily charged an extra $22.50 to be added to the service charge until the blood has been replaced by a volunteer donor; when this has been accomplished, a refund is immediately made.

The Blood Bank has all its business transactions with the hospitals and not with individuals. For the successful operation of the Bank it is important that the hospital, the physician, and the patient each does his part to see that this life-saving, pioneer organization is kept smoothly running.

It is to be hoped that, with the passing of time, there will be a growing realization by the practicing physician of the value of plasma in adequate amounts for the treatment of many disease conditions. In addition to surgical shock, it has been profitably used in acute pancreatitis, sunstroke, intestinal obstruction, in the toxemia and shock of many acute infections, in such conditions as nephrosis where there is a hypoproteinemia, and in post-operative pulmonary edema.

In conclusion, it should be emphasized that no civilian defense program and no preparation for a possible disaster from fire, explosion or other causes, is complete without a blood bank in operation, to provide plenty of plasma in the treatment of injured individuals. More-

over, further research in the use of blood substitutes in the treatment of disease can only be carried on in the laboratories of a blood bank. Even at this early date following its opening, units of concentrated blood cells, in other words plasma-free blood, has been provided for the treatment of severe anemia, and a universal blood O in which the plasma has been replaced by pooled plasma after the method of Litwins has been distributed. At present, tests for the Rh factor are being made so that Rh negative blood can be provided to pregnant mothers needing transfusions. These are only a few of the important problems that will undoubtedly arise and be studied in the laboratories of the Salt River Valley Blood Bank.

Louis B. Baldwin, M. D.

FUTURE ASPECTS PROCUREMENT AND ASSIGNMENT OF PHYSICIANS

Arizona has been highly complimented for serving our country so patriotically in the number of physicians it has supplied to the armed services. This has been done by our doctors in a commendable manner. We have left in Arizona, at the present, 345 physicians licensed to practice in the state, of this number we might say that 10 per cent are semi-active in that they do some work but have not for some time (prior to the war and since then) practiced on a full time basis. The greater percentage of these semi-retired physicians called at the Association offices or addressed us by letter when physicians were being reclassified for service and stated they would serve as needed. Those who have limited their practices because of failing health are continuing to maintain part time work and are keeping their licenses alive.

As to further physicians entering the armed services, Arizona will be expected to supply a small additional number from those within the age group and physicially available. This will be a very small number, indeed, from the present outlook. All physicians in Arizona stand ready with their services, civilian and otherwise, as needed.

Each physician is urged to remain in his present location and not to leave some small community for a larger one without notifying his local State Procurement and Assignment Service so that a replacement may be secured *before* a change is made.

Physicians and county medical society secretaries are asked to notify the undersigned of any changes in medical personnel in the various communities and counties. The letter following this report will be found of interest. We would like to know, promptly, of any deaths, departure from state, change in location within the state, county or community as soon as such change occurs. There has been some shift of physicians from some of the smaller counties to the larger ones, perhaps since the figures here were compiled; the totals, however, are essentially correct.

Signed,

Charles S. Smith, M. D.
Chairman, Procurement and Assignment of Physicians,
Nogales, Arizona.

Staff Meetings

GOOD SAMARITAN HOSPITAL STAFF
(Phoenix)

October 25, 1943

1. Primary Carcinoma of Fallopian Tube
   Dr. Kenneth E. Peterson.
2. Primary Sarcoma of Diaphragm.
   Dr. B. P. Frissell.

NOVEMBER 22, 1943

1. Disturbances of Urinary Bladder.
   Dr. J. W. Pennington.
2. Hodgkin's Disease.
   Dr. Howell Randolph.

ST. JOSEPH'S HOSPITAL STAFF
(Phoenix)

November 8, 1943

1. Case of Typhoid Fever Complicated by Symptomatic Purpura and Staphlococcic Endocarditis.
2. Case of Brain Abscess, with Operative Procedure, and Treatment with Penicillin, with Presentation of Patient.
   Dr. James L. Johnson,
   Dr. E. Payne Palmer.
3. Placentia Previa with Review of Hospital Cases During Past Year.
   Dr. Angus De Pinto.

December 13, 1943

I. Ureteral Lithiasis in a Case of Pregnancy.
Presented by Dr. John W. Pennington.

II. Clinical Pathological Case of Biliary Cirrhosis.
Presented by Dr. Tressa Moran.

III. Officers Elected for Executive Staff for year 1944:

Chairman.....Dr. James Lytton-Smith
Vice Chairman.....Dr. Norman A. Ross
Secretary.....Dr. Robert H. Stevens
Board Members:
Dr. Fred C. Jordan
Dr. E. Henry Running
Dr. Louis C. Jekel

IV. Following are the Active Staff Members

Dysart, Louis	McKeown, Hilton J.
Smith, Willard	Ovens, James
Caniglia, S. R.	Ploussard, Chas. N.
Cohen, Matthew	Ross, Norman A.
DePinto, Angus J.	Sharp, Floyd B.
Felch, Harry J.	Sult, Charles W., Sr.
Frissell, Ben Pat	Westervelt, M. W.
Jekel, Louis G.	Mills, H. P.
Lytton-Smith, James	Badlwin, L. B.
Milloy, Frank J.	Charvoz, Elton R.
Peterson, Kenneth	Denninger, Henri S.
Randolph, Victor S.	Drane, James E.
Schoffman, Wm. F.	Fournier, Dudley
Stevens, Robt H.	Irvine, Geo. B.
Woern, W. H.	Kingsley, A. C.
Palmer, E. P., Sr.	McVay, L. C.
Watkins, W. W.	Pennington, J. W.
Case, Paul H.	Randolph, Howell
Cruthirds, A. E.	Running, E. Henry
Dirks, Maitland S.	Sherrill, W. P.
Flinn, Robert	Williams, Henry
Hamer, J. D.	Moran, Tressa
Jordan, F. C.	

MARICOPA COUNTY MEDICAL SOCIETY

Monday, November 1, 1943, 8 P. M.

SYMPOSIUM ON PULMONARY DISEASE

Re-Expansion of Lungs.....Dr. Fred Holmes
Pleurisy with Effusion.....Dr. Robert Flinn
Atelectasis in Pulmonary Tuberculosis....
.....Dr. E. A. Gatterdam
Atopic Annoyances in the Course of Pulmonary TBC.....Dr. E. W. Phillips
Pneumoconiosis.....Dr. H. J. McKeown
Basal Tuberculosis.....Dr. V. Randolph

Meeting December 6, 1943

I. Two Moving Pictures through Courtesy of Winthrop Chemical Company.
1. Edema Cardiac and Renal
2. Human Sterility.

II. Election of officers for 1944.

President.....J. W. Pennington
Vice President.....Mayo Robb
Secretary.....Ben Pat Frissell
Directors.....Duke Gaskins, F. T. Fahlen
Board of Censors...H. L. Franklin for 3 years
F. C. Jordan for 1 year

PHYSICAL MEDICINE

(Released by National Foundation for Infantile Paralysis.)

The establishment of the first center for the scientific study and development of physical medicine as a branch of medical practise was announced today by Basil O'Connor, President of The National Foundation for Infantile Paralysis. The center will be in the Graduate School of Medicine of the University ofPennsylvania at Philadelphia.

To set up this center, Mr. O'Connor stated, The National Foundation for Infantile Paralysis has made a grant totaling $150,000 for a five-year period from January 1, 1944 to December 31, 1948.

Mr. O'Connor said, "We believe this to be one of the most important steps which the National Foundation has taken. This will not only advance the treatment of infantile paralysis, but of many other diseases as well."

Mr. O'Connor explained that today there is no school or department connected with any of the medical training centers which is equipped to explore thoroughly on a sound scientific basis the possibilities of physical medicine.

This is but the first step in a program which, Mr. O'Connor said, should afford a scientific basis for physical therapy and lead to the establishment of a more desirable teaching program.

"If this branch of medicine can be given a sound professional standing," Mr. O'Connor declared, "medical men of the hihgest calibre will be attracted to it and practitioners will fully utilize its advantages. If research and study show there is little or no basis for treatment by some of the physical agents, then an equally great service will have been rendered, even though it be principally negative in character.

"Physical medicine plays a most important part in the treatment of infantile paralysis. Since it was first organized, The National Foundation has been continuously concerned with this phase of treatment. It has spent during the past six years over $350,000 to educate and train physical therapy technicians. An additional $364,000 has been granted to laboratories and universities to study many problems in physiology and medicine having a close connection with the practice of physical therapy, but never before has it been possible to combine in one place both medical research and teaching in this important field."

The Center for Research and Instruction in Physical Medicine will include:

1. A center for development of physical medicine as a scientific part of the practice of medicine.
2. A training center for medical leaders and teachers in this branch of medicine, and
3. A school for training technical workers under the guidance of such professional and scientific leadership, such a school to be only incidental to and dependent upon the first two purposes.

The Departments of Anatomy, Physiology, Pathology and other basic sciences of the University of Pennsylvania will cooperate in this proposed program. The general direction will be assigned to Dr. Robin C. Buerki, Dean of the Graduate School of Medicine.

ANNUAL MEETING

Phoenix, Arizona

April 14-15, 1944

BUSINESS SESSION: FRIDAY, APRIL 14, Sessions of the Council and of the House

SCIENTIFIC SESSIONS: FRIDAY EVENING, APRIL 14; SATURDAY FORENOON AND AFTERNOON, APRIL 15

PROGRAM PRESENTED BY: GROUP OF INSTRUCTORS FROM UNIVERSITY OF SOUTHERN CALIFORNIA.

Friday Evening, April 14, 1944 8:00 to 10:00 P. M.

1. Coccidioides—clinical and pathological considerations
   Doctor Edward Butt and Doctor Arthur Hoffman
2. Clinical Pathological Conference

Saturday, April 15, 1944 9:30 to 12:00 A. M.

1. Fred Moore, M. D.
2. Gurth Carpenter, M. B., M. R. C. P.
3. Philip Cunnane, M. D.

2:00 to 4:00 P. M.

1. Doctor Carpenter
2. Clinical Pathological Conference.

COMPLETE PROGRAM IN MARCH ISSUE OF ARIZONA MEDICINE

DAN L. MAHONEY, M. D., Chairman
Committee on Scientific Assembly.

Make Your Reservations Early — Headquarters: Hotel Westward Ho

Woman's Auxiliary

STATE AUXILIARY OFFICERS AND COMMITTEE CHAIRMEN

PRESIDENT.....Mrs. Edward M. Hayden
314 N. Country Club Rd., Tucson

PRESIDENT-ELECT.....Mrs. James Allen
829 Crest Avenue, Prescott

FIRST VICE-PRESIDENT.....Mrs. Paul Case
718 W. MacDowell Rd., Phoenix

SECOND VICE-PRESIDENT.....Mrs. H. C. James
2634 East 4th, Tucson

RECORDING SECRETARY.....C. E. Bensema
Catalina Vista, Tucson

CORRESPONDING SECRETARY.....Mrs. B. B. Edwards
928 N. 2nd Ave., Tucson

TREASURER.....Mrs. E. H. Running
321 West Palm Lane, Phoenix

DIRECTORS: Mrs. B. B. Edwards, 928 N. 2nd Ave. Tucson
Mrs. J. D. Hamer, 1819 N. 11th Ave., Phoenix
Mrs. Harlan P. Mills, Rt. 2, Box 522, Phoenix

COMMITTEE CHAIRMEN

Cancer Project: Mrs. Hervey S. Faris, San Clemente Add'n. Tucson.
Legislative: Mrs. C. E. Patterson, 3 Paseo Redondo, Tucson
Public Relations: Mrs. Geo. L. Dixon, 2716 East 4th Street, Tucson.
Parliamentarian: Mrs. C. A. Thomas, Santa Rita Hotel, Tucson.
Publicity: Mrs. V. G. Presson, 1317 North Stone, Tucson.
Bulletin: Mrs. Dan L. Mahoney, 1916 East 4th St., Tucson
Hygia: Mrs. John L. Donahue, 2416 East Speedway, Tucson.
Historian: Mrs. Geo. B. Irvine, 1100 Mill Road, Tempe.
War Service: Mrs. J. D. Hamer, 1819 N. 11th Ave., Phoenix.

REPORT OF THE MID-SEASON BOARD MEETING
of the
WOMAN'S AUXILIARY TO THE AMERICAN MEDICAL ASSOCIATION

Chicago, Illinois - November 19, 1943

The mid-season board meeting of the Woman's Auxiliary to the American Medical Association was held in Chicago, Illinois on November 19, 1943, with Mrs. Eben J. Carey, the president, presiding.

In spite of the difficulties of travel, the meeting was very well attended, approximately fifty women being present.

In her president's report, Mrs. Carey stated that the American Medical Association has asked the auxiliary to assist with three major projects this year and they are as follows:

1. Assist in the promotion of the Nurse Cadet Corps.
2. Assist with the national registration of graduate nurses, this to be done under the direction of the Nurses' Association.
3. Help in every way possible to defeat the Wagner-Murray-Dingell Bill.

The finance committee offered the following recommendations which will be approved or disapproved at the annual meeting next June. They are:

1. To set aside 10% of the national dues as an emergency fund.
2. To raise the national dues to 75 cents capita.
3. To have a membership card printed.
4. That the Auxiliary buy a $1,000.00 bond.
5. That $1,000.00 be made available to the new officers immediately after the annual meeting.

The reports of the committee chairmen showed that fine programs have been set up for the year. The state presidents' reports told of many unusual and worthwhile projects. Among some of the outstanding work being done by state auxiliaries is blood typing and blood bank work; furnishing entertainment and assistance for girls in industrial centers, thus helping to prevent delinquency in many instances; loan funds; libraries and so on. All state auxiliaries are active in Red Cross and other war work. Hygeia is going along quite well, but should have much more support from the auxiliary as a whole, than it has had in the past.

The next annual meeting will be a full meeting. It will be held in Chicago from June 12-15, 1944, with headquarters at the Knickerbocker Hotel.

Respectfully submitted,

Clarice H. Hamer (Mrs. Jesse D.)
Director of the Woman's Auxiliary to the American Medical Association.

CONVENTION REPORT

Chicago June 7 - 9, 1943

The 21 annual meeting of the Woman's Auxiliary to the American Medical Association met in Chicago at the Drake Hotel on June 7-9, 1943. This meeting was a meeting of the House of Delegates since the regular convention had been cancelled due to the war. Any auxiliary member who wished to attend was more than welcome, however. There was an attendance of between three and four hundred.

The whole meeting was streamlined, but we were beautifully taken care of, both as to food and other comforts and conveniences.

The theme running through everything was our relationship to the war effort, how we could be of the most and best service to the whole program.

On Sunday, June 6, the Nominating commitee and the finance committee held their preconvention meetings and Monday morning was given over to the preconvention of the Board of Directors.

Monday noon the luncheon was in honor of the past presidents. This was held in the Gold Coast Room at the Drake and was very lovely. Mrs. M. A. Nix, the newly elected president of the Illinois auxiliary presided. There were the

auxiliary rather than outside of it, and also stresses the need for keeping our auxiliary alive if it is to be heard in the aftermath of the war—when the men come home we must be prepared to meet whatever challenge comes at that time.

The Legislative chairman reported that the study program which had been started the previous year had been carried on during the year. This being the study of Legislative Procedure.

The Public Relations chairman recommended promotion of health education for the general public, by sponsoring contests, posters and essays; working with the Cancer Control committee; giving scholarships for nurse and medical students; conducting health talks and clinics, etc.

The Hygeia chairman stated that 8582 subscriptions had been placed by April 7, 1943. Mrs. Edna Keck, Director of Health Education in Pennsylvania gets a large appropriation from the state for Hygeia, annually. Their slogan this year was Hygeia for health and victory.

Too much can not be said for the Bulletin, which is the national publication. Every auxiliary member should be a subscriber. The number of subscriptions is growing gradually, and this last year it was self-sustaining. It is purely an informative pamphlet, without thought of expansion into broader fields of journalism.

Some time was spent in discussing whether or not the auxiliary should have a pledge for the States to adopt. New members would be asked to sign it. The pledge proposed was as follows: "I pledge my loyalty and devotion to the Woman's Auxiliary to the American Medical Association. I will support its activities, protect its reputation and ever sustain its high ideals." The purpose of such a pledge would be to make the members aware of their responsibility and it might also bring home to us the dignity of the position we occupy as members of the Woman's auxiliary. There was no decision about the pledge.

National membership cards were discussed and referred to the incoming Board. It was thought that it might be nice for identification purposes, especially for the members in the Armed Forces. It might make it easier for them in making contacts with the medical groups in the communities where they find themselves.

A War Service Committee was set up as a standing committee, its duty being to develop a war service program to be sent to the state auxiliaries. Mrs. Rollo K. Packard is chairman of this committee.

The Doctors' Aide Corps, which was organized in Atlanta, Georgia, in August, 1942, with the endorsement of their Advisory Council was presented. Details of this project are written up in the December 1942 Bulletin.

long, slender birthday candles mixed in with the center piece, red ones and white ones, and as she read the names of the past presidents she lit a candle in their honor.

The main speaker at the luncheon was Dr. Frank P. Hammond, chairman of the Advisory committee to the Illinois auxiliary. His subject was "Doctors' Ladies, Medicines Strongest Ally." In speaking of the critical period which the medical profession is going through Dr. Hammond said that it is unbelievable that there are still Medical Societies that, not only discourage but turn down the efforts to organize Woman's Auxiliaries. In his opinion the auxiliary is or can be a powerful group, due to its sympathy and understanding of the practice of medicine as we have known it for the past generation and are remarkably well situated and equipped to publicize the methods and aims of the profession to the public through the normal established channels of community life throughout the country. He read a quotation from Mrs. Haggard which was as follows: "As your president, I shall have but one design—a single aim—and that is that we shall be so united, so strong, so forceful that no smallest opportunity from service shall pass us by . . . Whether we believe it or not, the greatest fight in this war is for moral order. We are all aware that the woman of this nation must quickly qualify herself to take her place where she is best fitted to serve. With members of the Woman's Auxiliary that place is fixed at once. There may be other places where is required to give her time and interest, but the auxiliary is on trial and must claim her best thought and effort. Of only secondary importance to munitions in defense comes health and the well being of the nation. Whatever we of the Woman's Auxiliary do in smaller circles, we have a profound duty toward the community and the nation at large. Everyone among us is fitted to do some particular thing well and to do it better than anyone without our advantages could possibly do it. It is because we are all working today that makes it possible for the medical profession to be so well organized for the national emergency. Never before have we faced such grave fears that our work might be rendered sterile, if we, as wives of doctors, relax vigilance and fail to meet the demands put upon us. With our nation at war we must attach ourselves to the things which will be of greatest assistance to the medical profession. There must be no doubt about the place we occupy in the national and medical defense programs."

Monday afternoon the meeting was opened in the usual manner. An address of welcome was given by Mayor Kelly. Mrs. Haggard in her "President's Address," stressed the point that the Woman's Auxiliary has striven to make its contribution to the war effort within the

States activities reported were: Red Cross work of all types, Civilian Defense, USO, Sale of Bonds and Stamps, Speakers' Bureaus, Radio programs, Cancer Control, Health talks and clinics, Chest drives, Well baby conferences, Ration Board Volunteer Service. Pennsylvania raised $1500.00 for a Blood Plasma Bank, a Kentucky auxiliary of 18 members sold $4000.00 worth of bonds, the Spokane, Washington auxiliary purchased a health film to be used in their schools, Idaho organized the Minute Maids, Wisconsin has a member on the State Legislative Council. The state of New York is especially active in legislative matters. Some state auxiliaries pay the dues for their members who are in the service, all states stressed the importance and placed much emphasis on the promotion of Hygeia and the Bulletin.

Tea was held in the Gold Coast Room, Monday afternoon honoring the out-going president, Mrs. Frank Haggard and the incoming president, Mrs. Eben Carey of Milwaukee.

Tuesday morning was given over to reports, summaries of which have been given.

The luncheon on Tuesday was in honor of Mrs. Haggard. The guest speakers were Dr. James E. Paullin, incoming president of the A.M.A. Dr. Morris Fishbein and Dr. Bauer.

Dr. James E. Paullin expressed interest in and appreciation of the aid which the auxiliary has been in developing medical programs for the counties and the states. He stated that he considered the A.M.A. fortunate in having such a group of women interested in the types of service and activities as have already been accomplished and equally grateful for the vision of the future and for the efforts in the present day needs.

Dr. Morris Fishbein talked on Post War Planning. He said: that regardless of what anyone thinks there will be tremendous changes in the practice of medicine. There must be jobs for ten million service men, 50 or 60,000 being medical men, besides the twenty million war workers. We must plan now for hospitals and health centers, where they are to be established, who is to run them, how they are to be financed and how managed. The auxiliaries can come to the aid of the medical profession and can find new outlets for service. An informed group such as the medical auxiliary can fit themselves well into a program of this kind and can render assistance that could not be supplied by any other group. They can contribute to the prevention of a world wide depression and can help in the reconstruction of the United States. He stated that the Board of Trustees is giving special attention to fitting back into civilian life 40,000 doctors who are now in the Armed forces. He feels that it will present the greatest opportunity that has ever arisen in this country to meet the challenge of distribution of medical care, the one charge that is made against medicine in the United States. It is now distributed according to the economic status of the communities. One way to arrive at proper distribution of medical care is to have available all of the necessary clinical, laboratory and scientific diagnostic facilities and aids to enable these men to practice the kind of medicine they were taught in medical school before they went into the service. He mentioned the Wagner-Murray-Dingell Bill which plans to extend social security to all of the people of the United States. The auxiliary is going to be asked to give to the Board of Trustees every assistance it can, the members can be a tremendous influence in affiliations with other organizations as well as in the auxiliary. In Dr. Fishbein's opinion it would be the height of folly if the Board of Trustees did not realize that in the woman's auxiliary they have a powerful weapon, capable of mobilizing vast forces in behalf of all that is good in medicine.

Dr. W. W. Bauer made the statement that the health of this nation is as good or better than that of any other nation and that the statistics about the great number of rejections are being changed. He brought out the fact that the medical profession must be kept before the public if it is going to keep its rightful place. The fifteen minute Broadcast of "Before The Doctor Comes" and the six broadcasts on "American Medicine Serves the World" were called to the group's attention.

At the post-convention board meeting the committee chairmen presented their programs for the coming year and an interesting talk on "Effect of the War on Medicine" by Dr. James P. Simonds, Professor of Pathology at Northwestern University then followed.

Dr. Simonds told the group that medical research is the basis of medical progress and that now research is given a new direction and scope. The volume has decreased some but those men that are remaining are doing more work. There are new things for the Army and the Navy; Teams of men are sent out by the government to have conferences regarding gas effects, blast injuries, bombs, depth bombs. This will continue after the war, there will continue to be research done on effects of high altitudes, treatment of wounds, etc. Industrial medicine is almost a new branch of medicine which is being developed. The war will no doubt have a permanent effect on medical education. Under the present system the student finishes high school, a committee studies his credentials, and he enters a college of his own choice, probably near his home. He may take an abbreviated course, just scientific subjects or a premedical course. If he does not show aptitude he is out and into the Army, if he is accepted he has to enter a medical school in his own corps area. If he enters medical October 1st he

goes through nine months then has one or two weeks vacation. He then begins his sophomore year and has one week between quarters and no summer vacation.

What effect this system will have on the students health is still a question, it is quite possible that it will be better. Under the old system the percentage of cases of tuberculosis was very high. Now the government furnishes the money. When the student has finished in three years instead of four, he goes into a hospital as an interne for a year, some then take a residency. This may have a tremendous repercussion. There may be a big demand for residency, they may not like private practice, it may have an effect on socialized medicine. Will the schools go back to the old system? The faculties are also working extra time. Dr. Simonds said that medical schools throughout the world have deteriorated, for instance Russia with twelve medical schools graduates more students than we do with seventy-two schools. One question is, what can the United States do to help reestablish the schools in other countries, Dr. Simonds feels that it is very important for the auxiliary members to acquaint themselves with the changes in medical education. Our legislation must provide social security for the weak and opportunity for the stronge. Post-war planning must take an important place.

Mrs. Eben J. Carey of Milwaukee, the incoming president in her address, brought out the fact that as doctors' wives we share an idealism and a standard of values held by few other groups. We are governed by the code of ethics that our husbands accept upon graduation from medical school. This war has brought to the auxiliary a challenge as well as an inspiration. We shall meet the challenge by concentrating our efforts on our war activities and through them we will assume the leadership in health education. The auxiliary will have to take on the medical society's work in public relations. We should be leaders and teachers in classes such as nutrition, nurses aides, first aid and so on. Mrs. Carey closed her talk by saying that our service is rewarded by the personal satisfaction of assisting the noblest profession on this Earth, the practice of medicine.

Respectfully submitted,

(Mrs. Jesse D.) Clarice Hamer
Official delegate to the National
Auxiliary Convention.

COUNTY AUXILIARY NEWS

Pima Auxiliary

The Pima County Medical Auxiliary is meeting the second Tuesday evening each month, coinciding with the regular meeting of the County Medical Society. There are 62 active members and 28 associate members.

The activities for the year include one half the meetings being held at the Red Cross work rooms, and the other half in the homes where we do sewing for the children of the Preventorium.

Mrs. L. H. Howard, Chairman of the Philanthropic Committee, purchased 43 pairs of pajamas for the boys and girls of the Preventorium; also 58 yards of outing flannel which we are working into pajamas. During the summer and fall, 110 garments, shoes, sox, quilts, books, and Christmas cards were donated by members and friends to the Preventorium.

During the summer, members met at the Red Cross room to sew and make surgical dressings.

Mrs. C. E. Patterson, Chairman of the Courtesy Committee, makes personal calls whenever possible upon wives of doctors in the armed services. They are especially invited to our meetings.

Mrs. George L. Dixon, Chairman of the Public Relations Committee, attended a meeting to encourage the enlistment of nurses in the army service.

Mrs. C. E. Patterson attended a meeting during the nation-wide campaign to encourage the women of Tucson to join the Waves.

Mrs. J. A. Omer, Hygeia Chairman, sent sample copies to 17 local organizaitons.

Eleven members have volunteered to sell Christmas seals.

Mrs. W. C. Davis, President, endeavors to keep the Auxiliary activities in accord with the added responsibilities of the members.

Publicity Chairman,
(Mrs. V. G.) Lillee Presson

MARICOPA AUXILIARY

The Maricopa Woman's Auxiliary meets in regular monthly session the first Monday of each month at which time the Medical Society also convenes. Following the two sessions, the groups join for a social hour. Auxiliary sessions opened this season with a tea.

Activities

Early in the season, the Auxiliary sponsored a dance, held at the Phoenix Country Club, for the benefit of the Blood Bank. The sum of $1,500 was cleared in this manner and donated to the Bank.

Additional projects will be undertaken when Mrs. Jesse D. Hamer returns from the National Board meeting and brings us recommendations made by that body. Mrs. Hamer is Regional Chairman of War Participation and will probably have returned and presented her report by the time this goes to press.

The Maricopa Auxiliary anticipates its full year of social, in keeping with current conditions, and civic activities.

Publicity Chairman
Ruth Hartgraves

GILA COUNTY MEDICAL SOCIETY NAMES OFFICERS

Dr. Clarence Gunter, Globe, was named president of the Gila County Medical Society at its annual meeting held Tuesday night in the Dominion Hotel. Other officers elected include: Dr. Ira E. Harris, vice president; Dr. Nelson D. Brayton, secretary-treasurer, and Dr. Russell R. Noice, censor. The latter three doctors are from Miami.

The meeting was in the form of a dinner party honoring the doctors' wives, and was under the supervision of Mrs. Cyril M. Cron, wife of the retiring president.

Upon adjournment of the business meeting, bridge was played by the ladies, with first prize going to Mrs. Gunter. Mrs. Harris took second and Mrs. Guy Ligon, low.

The society voted in favor of making the dinner party an annual efent.

The following members and their wives attended: Dr. and Mrs. Nelson D. Brayton, Dr. and Mrs. Cyril M. Cron, Dr. and Mrs. Adrian Clark, Dr. and Mrs. Clarence Gunter, Dr. and Mrs. Lee Gray, Dr. and Mrs. T. C. Harper, Dr. and Mrs. Charles B. Huestis, Dr. and Mrs. Russell R. Noice and Dr. and Mrs. Marcus G. Kelly.

Among the guests of the society were:

Mrs. Dixie Lee (Burton B.) LaDow, daughter of Dr. and Mrs. Brayton; Dr. and Mrs. Joseph G. Plant, Inspiration; Dr. and Mrs. Joseph Lee Sackler, San Carlos; Dr. and Mrs. Harold M. Gibbons, Miami; Dr. and Mrs. A. J. Boose, Globe; Dr. Waldo J. Lehman, formerly of India, now of Miami; Dr. and Mrs. Chester R. Swackhamer, Superior; Administrative Officer and Mrs. Guy Ligon, Miami-Inspiration Hospital, and Superintendent and Mrs. George Evans, Gila County Hospital.

ARMY TRAINS MEN WITH POOR VISION FOR LIMITED MILITARY SERVICE

About a thousand men a week, a majority of whom were rejected for active military service because of defective vision, now are entering the Army's Limited Service School for special training, according to the Better Vision Institute. Men with visual shortcomings entering the school, which gives a month's intensive training, outnumber two to one the men with all other defects combined. These men with poor eyesight have only about one-tenth to one-

Directory

ARIZONA STATE MEDICAL ASSOCIATION

Organized 1892

422 HEARD BUILDING, PHOENIX, ARIZONA

OFFICERS AND COUNCIL

O. E. Utzinger, M. D. (1947)..... Ray
President
Dan L. Mahoney, M. D. (1947)..... Tucson
President-Elect
Florence B. Yount, M. D. (1944)..... Prescott
Vice-President
Frank J. Milloy, M. D. (1944)..... Phoenix
Secretary
C. E. Yount, M. D. (1944)..... Prescott
Treasurer
F. W. Butler, M. D. (1944)..... Safford
Speaker of the House
Harold W. Kohl, M. D. (1944)..... Tucson
Delegate to A.M.A.
J. D. Hamer, M. D. (1945)..... Phoenix
Chairman Medical Defense

District Councilors

John W. Pennington, M. D. (1944)..... Phoenix
Central District (Gila, Maricopa, Pinal, Yuma)
George O. Bassett, M. D. (1943 ..... Prescott
Northern District (Apache, Coconino, Mohave, Navajo, Yavapai)
Chas P. Austin, M. D. (1945)..... Morenci
Southern District (Cochise, Greenlee, Graham Pima, Santa Cruz)
E. Payne Palmer, M. D..... Phoenix
Chairman of the Council

Councilors-at-Large

E. Payne Palmer, M. D. (1946 ..... Phoenix
*Hal W. Rice, M. D. (1945)..... Bisbee
D. F. Harbridge, M. D. (1944)..... Phoenix
*Serving unexpired term of W. Paul Holbrook in Service.

COMMITTEES

Scientific

Scientific Assembly — Dan L. Mahoney, President-Elect, Chairman, Tucson; T. C. Harper (1944), Globe; F. J. Milloy, (1945), Phoenix; D. W. Kittredge, Jr., Flagstaff, (1946); H. L. Franklin, (1944), Phoenix.

Scientific Education and Post Graduate Activities—A. H. Dysterheft, (1946), McNary; H. J. McKeown, (1944), Phoenix; Florence B. Yount, (1945), Prescott; Chas. S. Kibler, (1945, Tucson.

Industrial Health—C. B. Huestis, (1946), Hayden; C. P. Austin, (1944), Morenci; E. M. Hayden, (1945), Tucson.

Syphilis and Social Diseases—L. G. Jekel, (1946), Phoenix; O. B. Moon, (1944), Bisbee; Geo. O. Bassett, (1945), Prescott.

Maternal and Child Health—Hiward C. James, (1945), Tucson; Fred C. Jordan, (1944), Phoenix; W. P. Sherrill, (1946), Phoenix.

Orthopedics—E. W. Adamson, (1946), Douglas; Royal W. Rudolph, (1944), Tucson; Jas. Lytton-Smith, (1945), Phoenix.

Tuberculosis Control—Sam H. Watson, (1946), Tucson; Jas. H. Allen, (1944), Prescott; E. W. Phillips, (1945), Phoenix.

Cancer Control—E. Payne Palmer, Phoenix; M. G. Wright, Winslow; Geo. O. Hartman, Tucson; J. N. Stratton, Safford.

History and Obituaries—Historian, Hal W. Rice, Bisbee; J. D. Hamer, Phoenix; Frank J. Milloy, Phoenix.

Non-Scientific

Public Policy and Legislation—C. A. Thomas, (1944), Tucson; J. D. Hamer, (1945), Phoenix; Walter Brazie, (1946), Kingman.

Medical Defense—J. D. Hamer, Phoenix, Chairman; D. F. Harbridge, Phoenix; A. C. Carlson, Jerome.

State Health Relations—A. K. Duncan, (1944), Douglas; Donald F. Hill, (1945), Tucson; E. Henry Running, (1946), Phoenix.

Medical Economics—Meade Clyne, Tucson; Melvin L. Kent, Mesa; A. P. Kimball, (1946), Yuma.

Industrial Relations — C. E. Yount, Prescott, Chairman; Meade Clyne, Tucson; John W. Pennington, Phoenix; A. C. Carlson, Jerome; Jas. Lytton-Smith, Phoenix; Frank J. Milloy, Sec'y to Committee.

Public Health Education—H. L. McMartin, (1944), Phoenix; J. S. Gonzalez, (1946), Nogales; Paul H. Case, (1945), Phoenix; Geo. O. Bassett, Prescott.

Editing and Publishing—J. D. Hamer, (1944), Phoenix; D. F. Harbridge, (1945), Phoenix; Frank J. Milloy, (1946).

Auxiliary Advisory—Florence B. Yount, (1945), Prescott; J. D. Hamer, (1944), Phoenix; W. Claude Davis, (1946), Tucson.

twentieth of normal vision. Although one out of seven of the men with non-visual shortcomings are rehabilitated for general military service, very few of the men with eye defects are reclassified for general service. By utilization of the men from the school, thousands of other soldiers have been released for combat service.

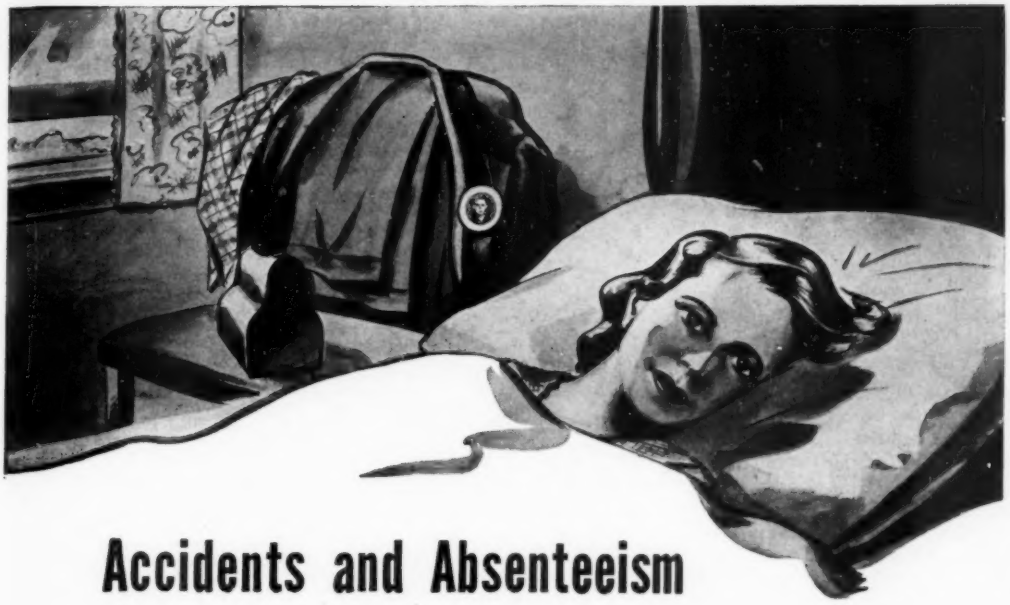
In countries where earrings have been popular a superstition is prevalent that piercing the ears and the wearing of gold earrings are beneficial to the eyes. However, as better understanding of the human body is brought about by wider education among the masses, the belief is losing currency, according to the Better Vision Institute.

Book Reviews

THE MIND OF THE INJURED MAN. By Joseph L. Fetterman, M.A., M.D., Pp. 260, with 28 illustrations. Industrial Medicine Book Company, Chicago, Illinois.

There is a tendency on the part of the medical profession to treat the disease or injury and not the patient; to overlook the fact that, figuratively speaking, scars of the mind as well as actual scars of the body may follow injury with residual impairment in function of the entire organism. Dr. Fetterman, in this book, discusses many of the mental disturbances which occur in the injured man and offers valuable suggestions for prevention and treatment of such conditions. He deals at some length on the anatomy and physiology of the nervous system and with many of the diseases and organic injuries which are frequently encountered. At least one-third of the book is taken up with the subject of neuroses, particularly as related to injuries, and it is this portion of the book which gives it importance. There is also an interesting discussion on malingering and psychopathic personality. A concise discussion of neuroses is given and several classifications enumerated. One classification which is of particular value in determining the course of treatment and the question of compensability is based upon the most significant factor involved in the production of the neurosis. Four types are given:

1. Injury neurosis—Due to actual organic damage to the nervous system.
2. Industrial neurosis—Due to dissatisfaction with the job and maladjustment.
3. Indemnity neurosis—Arising from compensation uncertainities, either actual or anticipated.
4. Inherent neurosis—Precipitated by accident but arising mainly from definite pre-existing nervous instability.



Accidents and Absenteeism

ACCIDENTS contribute to absenteeism. In women — particularly the conscientious middle-aged who try to stay on the job—the nervous symptoms associated with the menopause may directly affect their efficiency, and contribute to accidents of one kind or another.

For women in the menopause who require estrogenic therapy, the Squibb Laboratories supply *natural* estrogenic substance, Amniotin in Oil, and the *synthetic* estrogen, Diethylstilbestrol.

Physicians who prefer natural estrogens will find the vial packages of Amniotin in Oil very practical and economical. The three potencies which are available (20,000, 10,000 and 2,000 I.U. per cc.) offer a range suited to various patients. The vaccine-type cap permits the withdrawal of a dose of just the size to meet the patient's needs.

The lower cost and convenience of Squibb Diethylstilbestrol Tablets appeal to many busy physicians who are realizing more and more that the side effects of the synthetic estrogen are generally merely temporary, and that after a few days many patients gain tolerance to the drug so that they can take the tablets without discomfort and obtain the benefits afforded by oral administration.

Amniotin and Diethylstilbestrol Squibb are supplied in a variety of dosage forms for oral and hypodermic administration. Also in pessaries (vaginal suppositories).

For literature address the Professional Service Dept., 745 Fifth Avenue, New York 22, N. Y.

E·R·SQUIBB & SONS

Manufacturing Chemists to the Medical Profession Since 1858

KEEP ON BUYING MORE WAR BONDS

In an enlightening discussion of compensation problems in the neuroses of industry, the author frequently emphasizes his opinion regarding the pernicious and retarding effects of weekly or monthly compensation payments. Early settlement with a lump sum payment based upon a three to six months period is suggested as fair for the average case.

In his preface the author states that the book was written not only for the medical profession but for those laymen who have to do with the evaluation and adjudication of injury cases, such as industrial commissioners, claims agents, insurance adjusters and judges. This doubtless accounts for the elementary style and frequent simplified wording in parentheses following technical terms, even such terms as will ordinarily be familiar to the intelligent reader, at least to any reader sufficiently well informed to assimilate the general subject matter. For the reader who desires a more thorough and detailed technical discussion of the many subjects discussed, the author has compiled an extensive bibliography. The book is well bound, is printed on fine quality paper, and the numerous cuts and x-ray reproductions are of excellent quality. A reading of this book and a thorough study, at least of those portions pertaining to neurosis, is recommended to anyone dealing with injured cases, particularly those in which compensation is involved.

LOIS GRUNOW MEMORIAL LIBRARY

TRANSURETHRAL PROSTATECTOMY, by R. M. Nesbit. With a chapter on the "Vascular Supply of the Prostate Gland" by R. H. Flocks, 1943.

First description of a systematic and planned technique for performing transurethral operations upon the prostate gland! The publisher claims that neither the original materials of this text (inclusive of the author's text descriptions nor Didusch's original drawings are available elsewhere.

CLINICAL ANESTHESIA, by John S. Lundy. 1942.

Regional and general anesthesia for all surgery. DENTISTS: Note Chapters "Dental Local Anesthesia" and "General Anesthesia in Dentristy."

DISEASES OF THE NOSE, THROAT AND EAR: medical and surgical, by W. L. Ballenger and H. C. Ballenger, 8th ed. 1943.

The latest edition of this classic.

DISEASES OF THE BREAST, by Charles F. Geschickter. With a special section on treatment in collaboration with Murray M. Copeland. 1943.

Importance has been placed on microscopic pathology in the diagnosis and treatment of lesions of the breast. Benign and malignant growths comprise the greater part of the text.

PHYSIOLOGICAL BASIS OF MEDICAL PRACTICE, by C. H. Best and N. B. Taylor, 3rd. ed. 1943.

Physiology of all systems has been brought up to date. Physicians will welcome the interjection of remarks on the application of treatment to specific disturbances. There is now a Spanish and Portuguese edition of this text.

BRUCELLOSIS (UNDULANT FEVER), by H. J. Harris. 2nd. ed. 1941.

There has accumulated unmistakable evidence that chronic brucellosis is even more common than the acute form of disease. And so, Dr. Harris has collected all phases of this disease in one volume for the busy physician.

URINE AND URINALYSIS, by Louis Gershenfeld. 2nd. Ed. 1943.

Another classic which needs no annotation.

PRINCIPLES AND PRACTICE OF INDUSTRIAL MEDICINE, edited by F. J. Wampler. 1943.

The tremendous expansion of industries of all kinds, the vast number of people employed, the urgent necessity of

keeping them working in good health and under the healthiest possible conditions, have accentuated the special problems of industrial medicine. Here is the answer ot those problems.

OPERATING ROOM TECHNIC, by Anna M. O'Neill. 1943.
For the surgical supervisor and her staff.

HISTORY AND EVOLUTION OF SURGICAL INSTRUMENTS, by C. J. S. Thompson. 1942.
Many of these instruments were destroyed when the Nazi bombed London and the Royal College of Surgeons' building. Many of the phootgraphs and descriptions in this book are all that posterity will know of articles like Pare's cutting compass, cumbersome surgical saws, the first wooden specula, ancient operating tables and other records of the developing technic of surgery.

TEXTBOOK OF PERIODONTIA, by S. C. Miller and others. 2nd. ed. 1943.
Periodontoclasia is a disease long known but resisting all efforts made for its control until comparatively recent years. Here are visible evidences that the conquest of this disease can be prevented and, if not too far advanced, can be cured.

PSYCHOSOMATIC MEDICINE; the clinical application of psychopathology to general medical problems, by E. Weiss and O. S. English. 1943.
This is a book to help you solve your problem cases. It shows you how to cope with the obscure and complicated cases; the irritating patient. It tells you how to differentiate bodily symptoms of psychic origin from those of organic etiology; how to pick out the emotional factors complicating physical diseases; how to uncover the underlying causes of these emotional disturbances and how to institute practical and resultful therapy—in your office and at the bedside.

THERAPY OF THE NEUROSES AND PSYCHOSES, by S. H. Kraines, 2nd. ed. 1943.
The treatment of nervous and mental conditions is very frequently reserved for the specialist: but from one-third to three-quarters of the cases of the general practitioner or the non-psychiatric specialist are in need of psychotherapeutic as well as medical attention. This volume states as clearly as possible the factors underlying the formation of nervous and mental diseases and their treatment. Physicians other than psychiatrists will be able to make practical and valuable application of the principles of therapy herein discussed.

ORAL DIAGNOSIS WITH SUGGESTIONS FOR TREATMENT, by K. H. Thoma. 2nd ed. 1943.
This book covers diseases and abnromal conditions of the teeth, jaws, and other organs and tissues of the mouth, as well as suggestions for treatment. Secondary manifestations that are not diseases but are symptoms only of some general disturbances are considered. Somatic diseases caused by oral infection are also described.

LIBRARIES RESOURCES ARE OPEN TO MEMBERS OF THE MEDICAL AND DENTAL PROFESSIONS.

SHOULD VITAMIN D BE GIVEN ONLY TO INFANTS?

Vitamin D has been so successful in preventing rickets during infancy that there has been little emphasis on continuing its use after the second year.

But now a careful histologic study has been made which reveals a startling high incidence of rickets in children 2 to 14 years old. Follis, Jackson, Eliot, and Park* report that postmortem examination of 230 children of this age group showed the total prevalence of rickets to be 46.5%.

Rachitic changes were present as late as the fourteenth year, and the incidence was higher among children dying from acute disease than in those dying of chronic disease.

The authors conclude, "We doubt if slight

degrees of rickets, such as we found in many of our children, interfere with health and development, but our studies as a whole afford reason to prolong administration of vitamin D to the age limit of our study, the fourteenth year, and especially indicate the necessity to suspect and to take the necessary measures to guard against rickets in sick children."

*R. H. Follis, D. Jackson, M. M. Eliot, and E. A. Park: Prevalence of rickets in children between two and fourteen years of age, Am. J. Dis. Child. 66:11, July, 1943.

DIABETIC IDENTIFICATION TAGS

At the suggestion of the Medical Division of the U. S. Office of Civilian Defense, to prevent dangerous delay in diagnosis and to insure proper treatment during unconsciousness or coma, Eli Lilly and Company, Indianapolis, 6, Indiana, in cooperation with the American Diabetes Association, will provide metallic indentification tags to be worn by diabetic patients or carried in the pocket. The inscription reads "DIABETIC, If Ill Call PHYSICIAN." No advertising of any sort appears on the tags, which will be supplied to the medical profession on request.